Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel; (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay)

DATE: September 21, 2022

TO: Interested Parties

FROM: Paul Saucier, Director, Office of Aging and Disability Services

SUBJECT: Proposed Rulemaking: (1) Repeal 10-149 C.M.R. Ch. 5, Section 63, In-Home and Community Support Services for Elderly and Other Adults; (2) Repeal 14-197 C.M.R. Ch. 11, Consumer-Directed Personal Assistance Services; (3) Replace Section 63 and Chapter 11 with new Section 63, Home Based Supports and Services for Older and Disabled Adults; and (4) Amend 10-149 C.M.R. Chapter 5, Introduction, Table of Contents, Rule History

PUBLIC HEARING: October 13, 2022, at 1pm. Due to the ongoing threat posed by COVID-19, DHHS has determined that its public hearings will be conducted solely remotely, via ZOOM. This is in accordance with the DHHS Remote Rulemakings Hearings Policy issued September 10, 2021.To register, please use this link:
https://mainestate.zoom.us/j/88197875343?pwd=WUkvSHNsL2tOVTd0MWw1VHRGbVpxQT09

After registering, you will receive a confirmation email containing information about joining the hearing. Interpreter services will be provided during the hearing upon request.

COMMENT DEADLINE: Comments must be received by 11:59pm on October 24, 2022

The Department's proposed rulemaking proposes to:

(1) AMEND 10-149 C.M.R. Ch. 5, Introduction, Table of Contents, Rule History.
(2) REPEAL 10-149 C.M.R. Ch. 5, Section 63 ("Section 63"), In-Home and Community Support Services for Elderly and Other Adults.
(3) REPEAL 14-197 C.M.R. Ch. 11 ("Chapter 11"), Consumer-Directed Personal Assistance Services.
(4) REPLACE the Section 63 rule and the Chapter 11 rule with a new Section 63 rule, Home Based Supports and Services for Older and Disabled Adults.

The Department is proposing an effective date of July 1, 2023, for the amendment of the Chapter 5 Introduction rule, for the repeal of the current Chapter 11 and Section 63 rules, and for the replacement of those repealed rules with the new Section 63 rule. The current Chapter 11 rule and Section 63 rule will remain in effect through June 30, 2023.

10 149 C.M.R. Chapter 5, Introduction, Table of Contents, Rule History: The Department is updating the Introduction, deleting the Section 63 Table of Contents from the Chapter 5 Table of Contents, and updating the Rule History.

Section 63 and Chapter 11 rulemakings:

Resolves 2011, ch. 71 directed the Department to adopt a long-term services and supports plan, known as the "Lean Implementation Plan," and make its action items a work priority. One of the action items listed in the plan required the Department to prioritize the consolidation of two state-

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funded in-home care and community support services programs for elderly and other adults, currently codified as Section 63 and Chapter 11.

Stakeholder Engagement: In May 2019, the Department hosted a "Convening on Aging and Long-Term Services and Supports" with stakeholders to establish priorities for aging and long-term services and supports (LTSS) reform. This rulemaking implements one of the priorities recommended by stakeholders which was to update LTSS policies to bring programmatic inconsistencies into alignment where appropriate.

In July 2022, the Department held a "listening session" with various stakeholders to receive comments and suggestions on the merging of the two rules. Stakeholders included providers, consumers, the service coordination agencies, prospective sub-contractors, and the Long-Term Care Ombudsman Program. Stakeholders expressed support for the Department's plan to merge the rules but recommended that the Department "grandfather" Chapter 11 consumers so that these consumers would not be subject to the household asset limits in Section 63. Furthermore, stakeholders shared concerns that merging the rules could negatively impact consumers and urged the Department to maintain the same services wherever possible.

The differences between the proposed Section 63 rule and the current Section 63 and Chapter 11 rules include the following:

1. Updates the title of the rule to "Home Based Supports and Services (HBSS) for Older and Disabled Adults" to reflect current terminology;

2. Updates the definition of "Liquid Asset" in Section 63.02-25 to include revocable and irrevocable trusts;

3. Updates the eligibility section of the rule, Section 63.03-1(B), to require an eligible consumer to be "a resident of Maine";

4. Clarifies in rule that only the Department may terminate HBSS in Section 63.04-2;

5. Adds Section 63.04-4 which lists the reasons that an Assessing Service Agency, Service Coordination Agency or the Department can deny or terminate the consumer from receiving Consumer-Directed Services;

6. Removes diagnostic services under Section 63.05;

7. Clarifies the list of non-covered services in Section 63.06;

8. Creates a new subsection titled "Limits" (Section 63.07) to outline the total monthly costs of services for consumers receiving each level of care;

9. Creates a new subsection, Section 63.10, titled "Responsibilities of the Assessing Services Agency and the Service Coordination Agency" to organize all Assessing Services Agency and Service Coordination Agency responsibilities in one subsection of the rule;

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10. Streamlines Section 63.10-4 to specify that program reports must align with the provisions in the contract between the Department and the Service Coordination Agencies;

11. § 63.03-1(C) continues the current Section 63 requirements for liquid assets, except that Chapter 11 Consumers who are receiving Chapter 11 services on June 30, 2023, are exempt from this liquid asset requirement.

12. § 63.12-2 (Consumer Payment Formula for Former Chapter 11 Consumers) proposes a separate consumer payment formula for those Chapter 11 Consumers who were receiving Chapter 11 services on June 30, 2023.

13. § 63.12-3(A)(1)(a) (Waiver of Consumer Payment) proposes a separate household asset amount for determining eligibility for waiver of consumer payment for those Chapter 11 Consumers who were receiving Chapter 11 services on June 30, 2023.

14. Removes unnecessary and unused definitions and references to the Office of Elder Services.

Rules and related rulemaking documents may be reviewed at, or printed from, the OADS website at https://www.maine.gov/dhhs/oads/trainings-resources/policy.html or for a fee, interested parties may request a paper copy of rules by calling (207) 287-7055 or Maine Relay number 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process. Please address all comments to the agency contact person identified in the Notice of Agency Rulemaking Proposal

Notice of Agency Rulemaking Proposal

AGENCY: Department of Health and Human Services, Office of Aging and Disability Services

CHAPTER NUMBER AND RULE TITLES:

(1) 10-149 C.M.R. Chapter 5, Introduction, Table of Contents, Rule History (AMEND)
(2) 10-149 C.M.R. Chapter 5, Section 63, In-Home and Community Support Services for Elderly and Other Adults (REPEAL)
(3) 14-197 C.M.R. Chapter 11, Consumer Directed Personal Assistance Services (REPEAL)
(4) (4) 10-149 C.M.R. Chapter 5, Section 63, Home Based Supports and Services for Older and Disabled Adults (NEW RULE TO REPLACE REPEALED RULES)

TYPE OF RULE:

(1) 10-149 C.M.R. Chapter 5, Introduction, Table of Contents, Rule History (ROUTINE TECHNICAL)
(2) 10-149 C.M.R. Chapter 5, Section 63 (In Home and Community Support Services for Elderly and Other Adults) ("HYBRID" ROUTINE TECHNICAL & MAJOR SUBSTANTIVE RULE.) This rule is Routine Technical except for § 63.11 (Consumer Payments) which is a Major Substantive Rule provision pursuant to 34-B M.R.S. § 5439(9)).
(3) 14-197 C.M.R. Chapter 11 (Consumer Directed Personal Assistance Services) ("HYBRID" ROUTINE TECHNICAL & MAJOR SUBSTANTIVE RULE.) This rule is Routine Technical except for § 11.09 (Consumer Payments), which is a Major Substantive Rule provision pursuant to 34-B M.R.S. § 5439(9)).
(4) 10-149 C.M.R. Chapter 5, Section 63 (Home Based Supports and Services for Older and Disabled Adults) ("HYBRID" ROUTINE TECHNICAL & MAJOR SUBSTANTIVE RULE). This proposed new rule will be all Routine Technical except for § 63.12 (Consumer Payments), which is Major Substantive rule provision pursuant to 34-B M.R.S. § 5439(9).

PROPOSED RULE NUMBER:

BRIEF SUMMARY:

This proposed rulemaking proposes to:
(1) AMEND 10-149 C.M.R. Ch. 5, Introduction, Table of Contents, Rule History.
(2) REPEAL 10-149 C.M.R. Ch. 5, Section 63 ("Section 63"), In-Home and Community Support Services for Elderly and Other Adults.
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Date, time and location of PUBLIC HEARING *(if any)*: October 13, 2022, at 1pm. Due to the ongoing threat posed by COVID-19, DHHS has determined that its public hearings will be conducted solely remotely, via ZOOM. This is in accordance with the DHHS Remote Rulemakings Hearings Policy issued September 10, 2021. To register, please use this link: https://mainestate.zoom.us/j/88197875343?pwd=WUkvSHNsL2tOVTd0MWw1VHRGbVpxQT09

After registering, you will receive a confirmation email containing information about joining the hearing. Interpreter services will be provided during the hearing upon request.

COMMENT DEADLINE: Comments must be received by 11:59pm on October 24, 2022

CONTACT PERSON FOR THIS FILING *(include name, mailing address, telephone, fax, TTY, email)*:

Hilary Gove, Policy Writer
Maine Department of Health and Human Services
Office of Aging and Disability Services
41 Anthony Avenue
11 State House Station
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TTY: 711 (Deaf or Hard of Hearing)

CONTACT PERSON FOR SMALL BUSINESS IMPACT STATEMENT *(if different)*:N/A

FINANCIAL IMPACT ON MUNICIPALITIES OR COUNTIES *(if any)*: The Department does not anticipate a financial impact on municipalities or counties.

STATUTORY AUTHORITY FOR THIS RULE: 22 M.R.S. § 7303(2); 34-B M.R.S. § 5439(9); Resolves 2011, ch. 71

SUBSTANTIVE STATE OR FEDERAL LAW BEING IMPLEMENTED *(if different)*:N/A

AGENCY WEBSITE: https://www.maine.gov/dhhs/oads

EMAIL FOR OVERALL AGENCY RULEMAKING LIAISON: Sara.Gagne-Holmes@maine.gov

10
DEPARTMENT OF HEALTH AND HUMAN SERVICES
149
OFFICE OF AGING AND DISABILITY SERVICES
f/k/a/ OFFICE OF ELDER SERVICES

Chapter 5
POLICY MANUAL

Effective January 2, 2001

Note exceptions:
Sections 40, 61, 62, 63, 68, 69 amended effective July 1, 2003
Sections 40, 61, 62, 63, 65, 68, 69, 70 and 75 amended effective July 8, 2002
Section 73 amended effective July 1, 2001
Section 74 repealed effective July 8, 2002
Section 73 repealed effective August 10, 2004
Section 71 amended effective September 1, 2004
Sections 65, 67, 70, 75 amended effective September 1, 2004
Sections 40 and 63 amended effective October 4, 2004
Sections 63 and 69 amended effective October 30, 2005
Section 10 amended effective July 1, 2006
Section 69 amended effective July 2, 2006
Sections 11, 12, 14, 15, 16 effective October 6, 2007
Sections 68 and 69, effective February 1, 2009
Sections 63 and 69 amended (EMERGENCY) effective July 1, 2009
Sections 63 and 69 amended effective September 28, 2009
Sections 11, 12, and 14 repealed effective May 28, 2018
Section 63 repealed and replaced effective

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Telephone (207)624-5335
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TTY (Toll Free) 1(888)720-1925
Fax (207)624-5361

~~ANTI~~NON-DISCRIMINATION NOTICE

The Maine Department of Health and Human Services does not discriminate on the basis of sex, race, color, national origin, disability, age, gender, sexual orientation, religious or political belief, ancestry, familial or marital status, genetic information, association, previous assertion of a claim or right, or whistleblower activity, in admission or access to, or the operation of its policies, programs, services, or activities, or in hiring or employment practices.

This notice is provided as required by and i~~I~~n accordance with Title VI of the Civil Rights Act of 1964, as amended by the Civil Rights Restoration Act of 1991 (42 U.S.C. § 1981, 2000e *et seq*.)~~;~~, Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794)~~;~~ the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 *et seq*.)~~;~~ Title II of the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 *et seq*.)~~;~~ ~~and~~ Title IX of the Education Amendments of 1972~~;~~ ~~,~~Section 1557 of the Affordable Care Act; the Maine Human Rights Act; Executive Order Regarding State of Maine Contracts for Services; and all other laws and regulations prohibiting such discrimination. ~~the Maine Department of Health and Human Services does not discriminate on the basis of sex, race, color, national origin, disability or age in admission or access to treatment or employment in its programs and activities.~~

Questions, concerns, complaints or requests for additional information regarding the ADA and hiring or employment practices may be forwarded to the DHHS ADA/EEO Coordinators at 11 State House Station, Augusta, Maine 04333-0011; 207-287-1877 (V); 207-215-5980 (C); or Maine Relay 711 (TTY).

Questions, concerns, complaints or requests for additional information regarding the ADA and

programs, services, or activities may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-3707 (V); Maine Relay 711 (TTY); or ADA-CivilRights.DHHS@maine.gov.

Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 800-368-1019 or 800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA/Civil Rights Coordinator.

~~The Affirmative Action Officer has been designated to coordinate our efforts to comply with the U.S. Department of Health and Human Services regulations (45 C.F.R. Parts 80, 84 and 91) and the U.S. Department of Education (34 C.F.R. Part 106) implementing these Federal laws. Inquiries concerning the application of these regulations and our grievance procedures for resolution of complaints alleging discrimination may be referred to The Affirmative Action Officer at 221 State Street, Augusta, Maine 04333. Telephone number: (207) 287-3488 (Voice) or 1-800-332-1003 (TTY), or to the Assistant Secretary of the Office of Civil Rights, Washington, D.C.~~

Funding for this publication was made available through the
Maine Department of Health and Human Services
~~Office of Elder Services~~Office of Aging and Disability Services
Appropriation Number 010-10A-6000-012

TABLE OF CONTENTS . . . . . PAGE

The Section 63 Table of Contents is located with the Section 63 rule.

STATUTORY AUTHORITY

PL 99, Chap 4; 22 MRSA Sec. 312, 5106, 5107, 6203, 7303, 7915 and 24-A MRSA Sec. 6214

Recent History

EFFECTIVE DATE (ELECTRONIC CONVERSION):
May 5, 1996

AMENDED:
November 1, 1997

(Note: Section 61 is suspended from October 15, 1997 to January 13, 1998 by the emergency adoption of 10-144 Chapter 117. Section 62.03 is suspended from October 20 by emergency adoption 97-344 effective that date, and repealed effective November 1, 1997 by adoption 97-366. See 10-144 CMR Ch. 113 for the subject matter of Section 62.03.)

AMENDED:
December 24, 1997 - removal of three words from Section 68(D)

NON-SUBSTANTIVE CORRECTIONS:
February 13, 1998 - numbering corrected to 15.08 and 15.09 (had been in error 15.06 and 15.08

AMENDED:
June 2, 1998 - Section 71

NON-SUBSTANTIVE CORRECTION:
August 5, 1998 - rule reference in Section 71.05(F)(13)(b)

AMENDED:
September 23, 1998 - added Sections 73 and 74)
July 1, 1999 - Sections 40, 61, 62, 63, 68, 69, 73
August 14, 1999 - Sections 1, 40, 61, 62, 63, 66, 68, 69, 73

CORRECTION:
October 21, 1999 - restored the November 1, 1998 version of Section 71 as authorized by a September 3, 1999 memo from Assistant Attorney General Jane Gregory

AMENDED:
February 1, 2000 - Sections 61, 62, 63, 68, 69, 73 *(EMERGENCY - Major Substantive - undergoing legislative review)*
March 29, 2000 - routine technical changes to Sections 63, 69, 73
May 21, 2000 - major substantive changes to Sections 61, 62, 63, 68, 69, 73
January 2, 2001 - Sections 1, 15, 40, 61, 62, 63, 68, 69, 74

NON-SUBSTANTIVE CORRECTIONS:
February 5, 2001 - Introduction, Sections 10, 11, 12, 14, 16, 30, 64, 65, 66, 67, 70, 71, 72, 73 - punctuation and renumbering only

AMENDED:

July 1, 2001 -	Section 73
May 23, 2002 -	Section 73.02(A)(4), filing 2002-160 *(EMERGENCY - expires August 21, 2002.)* Note: the Department of Labor, Bureau of Rehabilitation Services, has been assigned rule-making power over this area of the Manual. The Manual is being reorganized in consequence and the relevant parts will be relocated to the Department of Labor when appropriate.

REPEALED:

July 8, 2002 -	Section 74, filing 2002-250

AMENDED:

July 8, 2002 -	Sections 40, 61, 62, 63, 65, 68, 69, and 70, filing 2002-250

NEW SECTION:

July 8, 2002 -	Section 75, filing 2002-250

AMENDED:

July 1, 2003 -	Sections 40, 61, 62, 63, 68, and 69, filing 2003-204

REPEALED:

August 10, 2004 -	Section 73, filing 2004-311

AMENDED:

September 1, 2004 -	Section 71, filing 2004-310
September 1, 2004 -	Sections 65, 67, 70, 75, filing 2004-367
October 4, 2004 -	Sections 40 and 63, filing 2004-427
October 30, 2005 -	Section 63, filing 2005-446
October 30, 2005 -	Section 69, filing 2005-447
July 1, 2006 -	Section 10, filing 2006-273
July 2, 2006 -	Section 69, filing 2006-291
October 6, 2007 -	Sections 11, 12, 14, 15, 16, filing 2007-423\
February 1, 2009 -	Sections 68 and 69, filing 2009-16
July 1, 2009 -	Sections 63 and 69, filing 2009-296 (EMERGENCY)
September 28, 2009 -	Sections 63 and 69, filing 2009-505
May 28, 2018 -	Sections 11, 12, and 14 repealed, filing 2018-086

REPEALED AND REPLACED

2023-	Section 63, filing xxxx-xxx

SECTION 63: IN-HOME AND COMMUNITY SUPPORT SERVICES FOR ELDERLY AND OTHER ADULTS

63.01 DEFINITIONS

(A) In-Home and Community Support Services for Elderly and Other Adults, hereinafter referred to as Home Based Care (HBC), is a state funded program to provide long term care services to assist eligible consumers to avoid or delay inappropriate institutionalization. Provision of these services is based on the availability of funds. State funds furnished through 22 MRSA §§ 7301-7306 and §§ 7321-7323 may not be used to supplant the resources available from families, neighbors, agencies and/or the consumer or from other Federal, State programs unless specifically provided for elsewhere in this section. State HBC funds shall be used to purchase only those covered services that are essential to assist the consumer to avoid or delay inappropriate institutionalization and which will foster independence, consistent with the consumer's circumstances and the authorized plan of care.

(B) **Activities of daily living (ADLs).** For purposes of eligibility ADLs shall only include the following as defined in Section 63.02(B): bed mobility, transfer, locomotion, eating, toileting, bathing and dressing.

(C) **Acute/Emergency.** Acute/Emergency means an unscheduled occurrence of an acute episode that requires a change in the physician ordered treatment plan or an unscheduled occurrence where the availability of the consumer's informal support or caregiver is compromised.

(D) **Assessing Services Agency (ASA)** Assessing Services Agency means an organization authorized through a written contract with Office of Elder Services to conduct face-to-face assessments, using the Department's Medical Eligibility Determination (MED) form, and the timeframes and definitions contained therein, to determine medical eligibility for MaineCare and state-funded covered services. Based upon a recipient's assessment outcome scores recorded in the MED form, the Assessing Services Agency is responsible for authorizing a plan of care, which shall specify all services to be provided under this Section, including the number of hours for services, and the provider types. The Assessing Services Agency is the Department's Authorized Agent for medical eligibility determinations and care plan development, and authorization of covered services under this Section.

(E) **Assisted Living Services** means the provision by an assisted housing program, either directly by the provider or indirectly through contracts with persons, entities or agencies, of assisted housing services, assisted housing services with the addition of medication administration or assisted

housing services with the addition of medication administration and nursing services.

(F) Authorized Agent means an organization authorized by the Department to perform functions, including intake, assessment and case management, under a valid contract or other approved, signed agreement. The Assessing Services Agency and any designated Home Care Coordinating Agency are Authorized Agents under this Section.

(G) Authorized Plan of Care means a plan of care which is authorized by the Assessing Services Agency, or the Department, which shall specify all services to be delivered to a recipient under this Section, including the number of hours for all covered services. The plan of care shall be based upon the recipient's assessment outcome scores, and the timeframes contained therein, recorded in the Department's Medical Eligibility Determination (MED) form. The Assessing Services Agency has the authority to determine and authorize the plan of care. All authorized covered services provided under this Section must be listed in the care plan summary on the MED form.

(H) Behavior threshold. Problem behavior is wandering with no rational purpose; or verbal abuse; or physical abuse; or socially inappropriate/disruptive behavior. A "threshold" score for problem behavior on the Medical Eligibility Determination (MED) form is equal to a score of 2 or 3 on one of these four criteria and occurs at least 4 days per week.

(I) Care Plan Summary is the section of the MED form that documents the Authorized Plan of Care and services provided by other public or private program funding sources or support, and their service category, reason codes, duration, unit code, number of units per month, rate per unit, and total cost per month.

(J) Cognitive capacity: The consumer who chooses to manage his or her own personal support services under the Family Provider Service Option as outlined in 63.10(C) must have cognitive capacity to do so. This capability will be determined by the Authorized Agent as part of the eligibility determination using the Medical Eligibility Determination (MED) findings. Minimum MED form scores are (a) decision making skills: a score of 0 or 1; (b) making self understood: a score of 0,1, or 2; (c) ability to understand others: a score of 0,1, or 2; (d) self performance in managing finances: a score of 0,1,or 2; and (e) support in managing finances, a score of 0,1,2, or 3. An applicant not meeting the specific scores will be presumed incapable of hiring, firing, training, and supervising the plan of care under the Family Provider Service Option.

(K) Cognitive threshold. Cognition is the ability to recall what is learned or known and the ability to make decisions regarding tasks of daily life. Cognition is evaluated in terms of:

(1) Memory: short-term and long-term memory;

(2) Memory/recall ability during last seven (7) days, or 24-48 hours if in a hospital; and

(3) Cognitive skills for daily decision making on a scale including: independent; modified independence; moderately impaired; severely impaired;

A "threshold" score for "impaired cognition" on the Medical Eligibility Determination (MED) form is equal to a score of 1 for loss of short term memory and 2 of items A-D or E none for memory/recall ability and a score of 2 or 3 for cognitive skills for decision making.

(L) Covered Services are those services for which payment can be made by the Department, under Section 63 of the Office of Elder Services policy manual.

(M) Cueing shall mean any spoken instruction or physical guidance which serves as a signal to do an activity. Cueing is typically used when caring for individuals who are cognitively impaired.

(N) Dependent Allowances. Dependents and dependent allowances are defined and determined in agreement with the method used in the MaineCare. The allowances are changed periodically and cited in the MaineCare Eligibility Manual, TANF Standard of Need Chart. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.

(O) Disability-related expenses: Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:

(1) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening, environmental controls;

(2) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response systems;

(3) Wheelchair (manual or power) accessories: lap tray, seats and back supports;

(4) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;

(5) Hearing Aids, glasses, adapted visual aids;

(6) Assistive animals (purchase only);

(7) Physician ordered medical services and supplies;
(8) Physician ordered prescription and over the counter drugs; and
(9) Medical insurance premiums, co-pays and deductibles.

(P) Extensive Assistance means although the individual performed part of the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was required and provided:
(1) Weight-bearing support three or more times, or
(2) Full staff performance during part (but not all) of the last 7 days.

(Q) Family Provider rates: The rates for Personal Support Specialist services under the Family Provider Service Option consist of three components: the employer expense component and the PSS family provider wage component and the payroll agent (FI) cost:
(1) **PSS rate** portion of the PSS rate that is designated as the PSS's gross hourly wage for authorized care provided by the family provider;
(2) **Family Provider expense component** the portion of the family provider rate designated as reimbursement to consumers for any mandated employer's share of social security, federal and state unemployment taxes, Medicare, and worker's compensation insurance premiums. Under this section a PSS who is the spouse, son or daughter of the consumer is not required to be covered by workers' compensation.
(3) **Administrative rate** Fee paid by the family provider to the FI for payroll services

(R) Family Provider Service Option a service provision option that allows an adult, twenty-one years or older, to register as a Personal Care Agency solely for the purpose of managing his or her own services or solely for managing the services of no more than two of his/her family members. For purposes of this definition only, family members include individuals related by blood, marriage or adoption as well as two unmarried adults who are domiciled together under a long- term arrangement that evidences a commitment to remain responsible indefinitely for each other's welfare.

(S) Fiscal Intermediary (FI) is an organization that provides administrative and payroll services on behalf of family providers who employ and manage their own support workers. FI services include, but are not limited to, preparing payroll withholding taxes, making payments to suppliers of goods and services and ensuring compliance with state and federal tax, labor and Home Based Care program requirements.

(T) Health Maintenance Activities are activities designed to assist the consumer with Activities of Daily Living and Instrumental Activities of Daily Living, and additional activities specified in this definition. These

activities are performed by a designated caregiver for an individual that would otherwise perform the activities, if he or she were physically able to do so and enable the individual to live in his or her home and community. These additional activities include, but are not limited to, catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, occupational and physical therapy activities such as assistance with prescribed exercise regimes.

(U) Home Care Coordinating Agency. The Home Care Coordinating Agency means an organization authorized, through a written contract with Office of Elder Services to conduct a range of activities on behalf of all consumers except for those receiving services through a Licensed Assisted Living Agency under Level V of this Section. The Home Care Coordinating Agency is responsible for the following: coordinate and implement the services in the consumer's plan of care authorized by the Assessing Services Agency; ensure that authorized services in the care plan summary are delivered according to the service authorizations; reduce, deny, or terminate services under this section; serve as a resource to consumers and their families to identify available service delivery options and service providers; answer questions; and assist with resolving problems. The Home Care Coordinating Agency is also responsible for administrative functions, including: maintaining consumer records; processing claims; overseeing and assuring compliance with policy requirements by any and all sub-contractors; final determination of the consumer copayment on receipt of the required information and collection of consumer co-payments: and conducting required utilization review activities.

(V) Income includes:

(1) Wages from work, including payroll deductions, excluding state and Federal taxes and employer mandated or court ordered withholdings;

(2) Benefits from Social Security, Supplemental Security Insurance, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;

(3) Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax; and

(4) Interest and dividends.

Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.

(W) Instrumental Activities of Daily Living (IADLs). For purposes of the eligibility criteria under this section of policy, IADLs are defined in section 63.02 (B) and are limited to the following: main meal preparation:

preparation or receipt of the main meal; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.

(X) Limited Assistance means the individual was highly involved in the activity over the past seven days, or 24 to 48 hours if in a hospital setting, but received and required

- guided maneuvering of limbs or other non-weight bearing physical assistance three or more times or
- guided maneuvering of limbs or other non-weight bearing physical assistance three or more times plus weight-bearing support provided only one or two times

(Y) Liquid asset is something of value available to the consumer that can be converted to cash in three months or less and includes:

(1) Bank accounts;
(2) Certificates of deposit;
(3) Money market and mutual funds;
(4) Life insurance policies;
(5) Stocks and bonds;
(6) Lump sum payments and inheritances; and
(7) Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form.

Funds which are available to the consumer but carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.

(Z) Long term care needs are those needs determined as a result of completion of the Medical Eligibility Determination form, resulting from an individual's inability to manage ADLs and IADLs, as a result of physical, emotional, or developmental problems.

(AA) A medical condition is unstable when it is fluctuating in an irregular way and/or is deteriorating and affects the client's ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment and management at least once every 8 hours is required. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and

~~medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. Not included in this definition is the loss of function resulting from a temporary disability from which full recovery is expected.~~

~~**(BB) Medical Eligibility Determination (MED) Form** shall mean the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form as defined in Section 63 provide the basis for services and the care plan authorized by the Assessing Services Agency. The care plan summary contained in the MED form documents the authorized care plan to be implemented by the Home Care Coordinating Agency in the service order or, for Level V, by the Licensed Assisted Living Agency. The care plan summary also identifies other services the recipient is receiving, in addition to the authorized services provided under this Section.~~

~~**(CC) Multi-disciplinary team (MDT). The MDT** includes the consumer, the designated home care coordinating agency staff person as appropriate, the RN assessor, or a health professional and may also include other people who provide or have an interest in the consumer's services.~~

~~**(DD) One-person Physical Assist** requires one person over the last seven (7) days or 24-48 hours if in a hospital setting, to provide either weight-bearing or non-weight bearing assistance for an individual who cannot perform the activity independently. This does not include cueing.~~

~~**(EE) Personal Support Services** are those covered ADL and IADL services provided by a home health aide, certified nursing assistant or personal support specialist which are required by an adult with long-term care needs to achieve greater physical independence, in accordance with the authorized plan of care.~~

~~**(FF) Personal Support Specialist (PSS)** is a person who provides personal support services for ADL and IADL needs and has completed a Department approved training course of at least 50 hours, unless otherwise exempt under Section 63, which includes, but is not limited to, instruction in basic personal care procedures, such as those listed in Section 63.02(B)(1)(b), first aid, handling of emergencies and review of the mandatory reporting requirement under the Adult Protective Services Act. PSS are unlicensed assistive personnel as defined in Title 22 MRSA §1717(1)(D).~~

(GG) Provider means any entity, agency, facility or individual who offers or plans to offer any in-home or community support services.

(HH) Residential care facility - means a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services. Residential care facilities provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. "Residential Care facility" does not include a licensed nursing home or a supported living arrangement certified by DHHS (formerly DBDS) for behavioral and developmental services.

(II) Service order means the document used by the Home Care Coordinating Agency to engage and order the subcontractor or independent contractor to complete the tasks, authorized by the Assessing Services Agency on the care plan summary of the MED form. The hours on the service order shall not exceed the hours authorized on the MED form care plan summary and must include only the covered services from Section 63.04.

(JJ) Significant change. A significant change is defined as a major change in the consumer's status that is not self limiting, impacts on more than one area of their functional or health status, and requires multi-disciplinary review or revision of the plan of care. A significant change assessment is appropriate if there is a consistent pattern of changes, with either two or more areas of improvement, or two or more areas of decline, that requires a review of the care plan and potential for a level of care change.

(KK) Signature. Effective with the implementation of the computerization of the Medical Eligibility Determination (MED) form, signature of the RN assessor or the HCCA staff will equate with "login" onto the appropriate electronic system.

(LL) Skills training-consumer instruction - Instructional services provided by the HCCA to assist family providers under the Family Provider Option who have attained prior authorization for PSS services, in developing the skills and activities related to the fiscal intermediary.

(MM) Total Dependence means full staff person/caregiver performance of the activity during the entire last seven (7) day period across all shifts, or during each eight hour period in twenty four (24) hours. .

(NN) Unlicensed Assistive Personnel means individuals, including personal support specialists and homemakers, who, as defined in Title 22 MRSA §1717, are employed to provide hands-on assistance with daily living to individuals in homes, assisted living centers, residential care facilities, hospitals and other health care settings. Unlicensed assistive personnel

does not include certified nursing assistants employed in their capacity as certified nursing assistants.

(OO) Licensed Assisted Living Agency means a provider that is licensed by the Department as an Assisted Living Program **and** that holds a valid contract with the Office of Elder Services to provide assisted living services for consumers eligible to receive services under Level V of this Section. These providers employ certified residential medication aides (CRMA's) with the intention to serve consumers who have daily medication administration needs pursuant to Level V eligibility. The Licensed Assisted Living Agency is responsible for delivering services in the consumer's plan of care as authorized by the Assessing Services Agency; ensuring that the authorized services in the care plan summary are delivered according to the service authorizations; and reducing, denying or terminating services, as appropriate, under this Section. The Licensed Assisted Living Agency is also responsible for administrative functions, including: maintaining consumer records; submitting claims; and final determination of the consumer co-payment on receipt of the required information and collection of consumer co-payments.

(PP) Medication Administration for Level V is the daily administration of routine prescription medications by a Licensed Assisted Living Agency performed by a Certified Residential Medication Aide (CRMA) under the supervision of a registered Nurse.

(QQ) Personal Care Services includes personal support services and medication administration.

63.02 ELIGIBILITY

(A) General and Specific Requirements. To be eligible for services a consumer must:

(1) Be at least 18;

(2) Live in Maine;

(3) For an individual, have liquid assets of no more than $50,000, or for couples have assets of no more than $75,000.

(4) Lack sufficient personal and/or financial resources for in-home services;

(5) Be ineligible for the MaineCare Private Duty Nursing/Personal Care Services except as otherwise provided in this Section, MaineCare Home and Community Based Waiver, MaineCare Adult Day Health, MaineCare Consumer-Directed Attendant Services programs;

(6) Not be participating in Section 61: Adult Day Services, Section 62: Independent Housing with Services, Section 68: Respite Care for People with Alzheimer's Disease or Related Disorders, Section 69: Office of Elder Services Homemaker Services or Consumer-

Directed Home Based Care program enacted by 26 MRSA §1412-G;

(7) Not be residing in a Residential Care facility; a supported living arrangement certified by DHHS for behavioral and developmental services; or a licensed or unlicensed Assisted Living Program except for those that meet the definition of a Licensed Assisted Living Agency set forth in Section 63.01(OO);

(8) Not be residing in a hospital or nursing facility;

(9) Consumer or legal representative agrees to pay the monthly calculated consumer payment; and

(10) If the assessment for continued eligibility indicates medical eligibility for a MaineCare program and potential financial eligibility for MaineCare, consumers will be given written notice, that the consumer has up to thirty (30) days to file a MaineCare application. If HBC services are currently being received, services shall be discontinued if an Office of Integrated Access and Support notice is not received within thirty (30) days of the assessment date indicating that a financial application has been filed. Services shall also be discontinued if, after filing the application within thirty (30) days the application requirements have not been completed in the time required by MaineCare policy. No further notice of termination is required in order for the termination to be effective as soon as MaineCare eligibility is established. Service under this section will not be terminated if MaineCare eligibility is denied.

(B) Medical and Functional Eligibility Requirements

Applicants for services under this section must meet the eligibility requirements as set forth in this Section 63.02(B) and documented on the Medical Eligibility Determination (MED) form. Medical eligibility will be determined using the MED form as defined in Section 63.01. A person meets the medical eligibility requirements for Home Based Care if he or she requires a combination of items from Activities of Daily Living 63.02(B)(1)(b), Instrumental Activities of Daily Living Section 63.02(B)(1)(c) and Nursing Services 63.02(B)(1)(d) or, for Level V, medication administration. The levels of care define which combined items are required for each level of care. 63.02 (1) OR (2) OR (3) OR (4) OR (5) below. The clinical judgment of the Department's Assessing Services Agency shall be the basis of the scores entered on the Medical Eligibility Determination (MED) form.

(1) **Level I** A person meets the medical eligibility requirements for Level I of Home Based Care if he or she requires the combination of criteria of Activities of Daily Living, Instrumental Activities of Daily Living and Nursing Services, as described below:

(a) Eligibility items

(i) Requires cueing 7 days per week for eating, toilet use, bathing, and dressing as defined in Section 63.01(L); or

(ii) Requires limited assistance plus a one person physical assist with at least two (2) ADLs from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing and assistance/done with help plus physical assistance with at least one (1) IADL; or

(iii) Requires limited assistance plus a one person physical assist with at least one (1) ADL from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing and assistance/done with help plus physical assistance with at least two (2) IADLs from the following: main meal preparation, routine housework, grocery shopping, and laundry; or

(iv) Requires limited assistance plus a one person physical assist with at least three (3) ADLs from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing or

(v) Requires one of the nursing services items i – xi below, at least once per week, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described in Section 63.02(B)(1)(d) below and limited assistance plus a one person physical assist with at least two (2) ADLs from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing: or

(vi) Requires two (2) of the nursing services items i – xi below, at least once per week, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described in Section 63.02 (B)(1)(d) below and limited assistance plus a one person physical assist with at least one (1) ADL from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing or

(vii) Requires one of the nursing services items i – xi below, at least once per week, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described in Section 63.02 (B)(1)(d) below and limited assistance plus a one person physical assist with at least one (1) ADL from the following: bed mobility,

~~transfer, locomotion, eating, toilet use, dressing, and bathing and assistance/done with help plus physical assistance with at least one (1) IADL from the following: main meal preparation, routine housework, grocery shopping, and laundry:~~

~~**(b) Activities of Daily Living:**~~

~~(i) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;~~

~~(ii) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);~~

~~(iii) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;~~

~~(iv) Eating: How person eats and drinks (regardless of skill);~~

~~(v) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;~~

~~(vi) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and~~

~~(vii) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.~~

~~**(c) Instrumental activities of daily living.**~~

~~(i) "Instrumental activities of daily living (IADLs)" are regularly necessary home management activities listed below:~~

~~(ii) Daily instrumental activities of daily living (within the last 7 days):~~

~~(aa) main meal preparation: preparation or receipt of main meal;~~

~~(iii) Other instrumental activities of daily living (within the last 14 days):~~

~~(aa) routine housework: includes, but is not limited to vacuuming, cleaning of floors, trash removal, cleaning bathrooms and appliances;~~

~~(bb) grocery shopping: shopping for groceries and storage of purchased food or prepared meals;~~

~~(cc) laundry: doing laundry in home or out of home at a laundry facility;~~

~~**(d) Nursing Services**~~

~~(i) intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of unstable conditions requiring medical or nursing intervention other than daily insulin injections for an individual whose diabetes is under control;~~

~~(ii) nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;~~

~~(iii) nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within past 30 days) or unstable condition;~~

~~(iv) treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);~~

~~(v) administration of oxygen on a regular and continuing basis when the recipient's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;~~

~~(vi) professional nursing assessment, observation and management of an unstable medical condition (observation must, however, be needed at least once every eight hours throughout the 24 hours);~~

~~(vii) insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the recipient's medical record;~~

~~(viii) services to manage a comatose condition;~~

~~(ix) care to manage conditions requiring a ventilator/respirator;~~

~~(x) direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e.:~~

grandmal);

(xi) physician-ordered occupational, physical, or speech/language therapy or some combination of the three (time limited with patient-specific goals) which is provided by, and requires the professional skills of a licensed or registered therapist. (Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist.) Maintenance or preventive services do not meet the requirements of this section;

(2) Level II. A person meets the medical eligibility requirements for Level II of Home Based Care if he or she requires any of the nursing services, items i to xvi below, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described below in Section 63.02(B)(2)(a)

(a) Nursing Services

(i) intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of unstable conditions requiring medical or nursing intervention other than daily insulin injections for an individual whose diabetes is under control;

(ii) nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;

(iii) nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within past 30 days) or unstable condition;

(iv) treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

(v) administration of oxygen on a regular and continuing basis when the recipient's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;

(vi) professional nursing assessment, observation and management of an unstable medical condition

~~(observation must, however, be needed at least once every eight hours throughout the 24 hours);~~

~~(vii) insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the recipient's medical record;~~

~~(viii) services to manage a comatose condition;~~

~~(ix) care to manage conditions requiring a ventilator/respirator;~~

~~(x) direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e.: grandmal);~~

~~(xi) physician-ordered occupational, physical, or speech/language therapy or some combination of the three (time limited with patient-specific goals) which is provided by, and requires the professional skills of a licensed or registered therapist. Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist. Maintenance or preventive services do not meet the requirements of this section; or~~

~~(xii) Professional nursing assessment, observation and management of a medical condition;~~

~~(xiii) administration of treatments, (excluding nebulizers, CPAP or BIPAP systems and airway clearance system vest), procedures, or dressing changes which involve prescription medications for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring;~~

~~(xiv) professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis;~~

~~(xv) professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;~~

~~(xvi) professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;~~

~~**(a) In addition to above, one of the following:**~~

~~(i) requires daily (7 days per week) "Cueing" (defined in Section 63.01(L)) for all of the following criteria:~~

63.02(B)(2)(c)(eating, toilet use, bathing, and dressing),

OR

(ii) At least "limited assistance" (defined in 63.01(U)) and a "one person physical assist" (defined in 63.01(AA) is needed with at least two of the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing as defined below in Section 63.02(B)(2)(c):

(b) Activities of Daily Living:

(i) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

(ii) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

(iii) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

(iv) Eating: How person eats and drinks (regardless of skill);

(v) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;

(vi) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and

(vii) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

(c) Instrumental activities of daily living.

"Instrumental activities of daily living (IADLs)" are regularly necessary home management activities listed below:

(i) Daily instrumental activities of daily living (within the last 7 days)

(aa) main meal preparation: preparation or receipt of main meal;

(ii) Other instrumental activities of daily living (within the last 14 days):

(bb) routine housework: includes, but is not limited to vacuuming, cleaning of floors, trash removal, cleaning bathrooms and appliances;

(cc) grocery shopping: shopping for groceries

and storage of purchased food or prepared meals;

(dd) laundry: doing laundry in home or out of home at a laundry facility;

(3) Level III A person meets the medical eligibility requirements for Level III of Home Based Care if he or she requires at least "limited assistance and a "one person physical assist" in two of the following five ADLs: and assistance/done with help plus physical assistance with at least three IADLs from the following:

(a) Activities of Daily Living:

(i) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

(ii) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

(iii) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

(iv) Eating: How person eats and drinks (regardless of skill);

(v) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;

(b) Instrumental activities of daily living.

"Instrumental activities of daily living (IADLs)" are regularly necessary home management activities listed below:

(i) Daily instrumental activities of daily living (within the last 7 days)

(aa) main meal preparation: preparation or receipt of main meal;

(ii) Other instrumental activities of daily living (within the last 14 days):

(aa) routine housework: includes, but is not limited to vacuuming, cleaning of floors, trash removal, cleaning bathrooms and appliances;

(bb) grocery shopping: shopping for groceries and storage of purchased food or prepared meals;

(cc) laundry: doing laundry in home or out of home at a laundry facility;

(4) Level IV A person meets the medical eligibility requirements for this level IV of Home Based Care if he or she meets the medical eligibility requirements for nursing facility level of care set forth in Chapter 2, Section 67.02-3 Nursing Facility Services of the MaineCare Benefits Manual.

(5) Level V. Personal Care Services for Consumers with Daily Medication Needs. An individual meets the medical eligibility requirements for Level V if the following are met:

1. The individual requires daily assistance with medication administration for routine prescription medications delivered by a CRMA and physical assistance with at least 2 IADLs; **or**

2. The individual requires daily assistance with medication administration for routine prescription medications delivered by a CRMA and physical assistance with at least 1 ADL; **or**

3. The individual meets eligibility for Level I, II or III under this Section and resides in a facility that meets the requirements of being a Licensed Assisted Living Agency as defined in Section 63.01(OO).

63.03 DURATION OF SERVICES

Each Home Based Care consumer may receive as many covered services as are required within the limitations and exceptions as described below. Home Based Care coverage of services under this Section requires prior authorization from the Department or its Assessing Services Agency. Beginning and end dates of a consumer's medical eligibility determination period correspond to the beginning and end dates for Home Based Care coverage of the plan of care authorized by the Assessing Services Agency or the Department.

(A) Exception to the Limit: For consumers accessing Adult Day Services reimbursed by HBC funds, the caps may be exceeded by an amount determined by the Department.

(B) Consumers classified for Level I level of care (see Section 63.02(B)(1)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level I" cap, established by the Department.

(C) Consumers classified for Level II level of care (see Section 63.02(B)(2)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level II" cap established by the Department.

(D) Consumers classified for Level III level of care (see Section 63.02(B)(3)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level III" cap established by the Department.

(E) Consumers classified for Level IV level of care (see Section 63.02(B)(4)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or 80% of the average cost of MaineCare nursing facility level of care established by the Department.

(F) Consumers classified for Level V level of care (see Section 63.02(B)(5)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level V" cap established by the Department.

(G) Suspension. Services may be suspended for up to thirty (30) days. If the circumstances requiring suspension extend beyond thirty (30) days, the consumer's eligibility in the program will be terminated.

(H) Services under this Section shall be reduced, denied or terminated by the Department, the Assessing Services Agency, the Licensed Assisted Living Agency or the Home Care Coordinating Agency, as appropriate, for one or more of the following reasons:

(1) The consumer does not meet eligibility requirements;

(2) The consumer declines services;

(3) The consumer is eligible to receive long-term care services under MaineCare including any MaineCare Special Benefits, except as otherwise provided in this section for MaineCare Private Duty Nursing/Personal Care Services;

(4) The consumer is eligible and chooses to receive services under the Consumer Directed Home Based Care Program enacted by 26 MRSA §1412-G;

(5) The consumer appears to be eligible for long term care services under MaineCare pursuant to the procedure set forth in Section 63.02(A)(10);

(6) Based on the consumer's most recent MED assessment, the plan of care is reduced to match the consumer's needs as identified in the reassessment and subject to the limitations of the program;

(7) The health or safety of individuals providing services is endangered; or

(8) Services have been suspended for more than thirty (30) days; or

(9) Consumer refuses personal care or nursing services; or

(10) Consumer has failed to make his/her calculated monthly co-payment within thirty (30) days of receipt of the co-pay bill; or

(11) When the consumer or designated representative gives fraudulent information to Department of Human Services, the Assessing Services Agency or Home Care Coordinating Agency; or

(12) The consumer is eligible to receive home health services for some or all of the services authorized under this section from Medicare

or another third party payer; or

(13) The availability of informal or formal supports, including public and private sources, duplicate the services provided under this section; or

(14) There are insufficient funds to continue to pay for services for all current consumers which results in a change affecting some or all consumers.

Notice of intent to reduce, deny, or terminate services under this section will be done in accordance with Section 40.01 of this policy manual.

63.04 COVERED SERVICES

Covered services are available for consumers meeting the eligibility requirements set forth in Section 63.02. All covered services require prior authorization by the Department, or its Assessing Services Agency, consistent with these rules, and are subject to the limits in Section 63.03. The Authorized Plan of Care shall be based upon the consumer's assessment outcome scores recorded on the Department's Medical Eligibility Determination (MED) form, according to it's its definitions, and the timeframes therein and the Task Time Allowances defined in the appendix to this section.

Services provided must be required for meeting the identified needs of the consumer, based upon the outcome scores on the MED form, and as authorized in the plan of care. Coverage will be denied if the services provided are not consistent with the consumer's authorized plan of care. The Department may also recoup payment from the Home Care Coordinating Agency or Licensed Assisted Living Agency for inappropriate services provision, as determined through post payment review. The Assessing Services Agency has the authority to determine the plan of care, which shall specify all services to be provided, including the number of hours for each covered service.

The Assessing Services Agency will use Task Time Allowances set forth in the appendix to this section to determine the time needed to complete authorized ADL tasks for the plan of care not to exceed the program limits specified elsewhere in this section.

Covered Services are:

(A) Care Management, or case management, by the Home Care Coordinating Agency is a system for identifying, implementing, locating, coordinating, reviewing, and monitoring consumer's need for services as authorized by the Assessing Services Agency during the eligibility determination process.

~~Care Management tasks performed by a Home Care Coordinating Agency which are required for overall program administration, management, distribution of funds and reporting include, but are not limited to:~~

~~(1) Ensuring the implementation, monitoring and modification of the consumer plan of care authorized by the Assessing Services Agency;~~
~~(2) Advocating on behalf of the consumer for access to appropriate community resources;~~
~~(3) Implementing the Assessing Services Agency authorized care plan and coordinating of service providers who are responsible for delivery of services pursuant to the consumer's authorized plan of care and identified needs;~~
~~(4) Maintaining contacts, on behalf of the consumer, with family members, designated representative, guardian, providers of services or supports and the Assessing Services Agency to ensure the continuity of care and coordination of services;~~
~~(5) Monitoring the services and support; and evaluating the effectiveness of the plan with the consumer or the designated representative, guardian and providers of services or support;~~
~~(6) Calculating the consumer's co-payment based on the estimated copayment determined by the Assessing Services Agency and receipt and review of the documented dependent allowances and disability related expenses. Consumers receiving services under this section may be selected for verification of income and assets;~~
~~(7) Notifying the Assessing Services Agency of the due date of the annual financial reassessment.~~
~~(8) Coordinating and requesting of required and unscheduled reassessments including the provision of an up to date status report of the consumer and their situation.~~
~~(9) Preparing the consumer for the reassessment process.~~
~~(10) Beginning discharge planning on the first day of services. A discharge plan will enable the consumer to transition to other services, as appropriate;~~
~~(11) In the event a consumer experiences an unexpected need, the Home Care Coordinating Agency has the authority to adjust the frequency of services under the authorized care plan, in order to meet the needs, as long as the total authorized care plan hours for the eligibility period are not exceeded~~
~~(12) In the event a consumer experiences an emergency or acute episode as defined in Section 63.01(C), the Home Care Coordinating Agency has the authority to adjust the authorized plan of care up to 15% of the monthly authorized amount not to exceed the applicable cap. Services resulting from an acute or emergency incident may not continue beyond fourteen (14) days~~

and the Home Care Coordinating Agency must request a reassessment on the date the increase is implemented;

(13) Issuing a "notice of intent to reduce, deny or terminate HBC services" as defined and applicable in Section 63.03.

(14) Other administrative tasks include, but are not limited to:

(a) Processing assessment packets;

(b) Maintaining consumer records;

(c) Tracking and reporting services;

(d) Preparing the Home Care Coordinating Agency budget and processing of claims to the Department;

(e) Contracting with service providers including fiscal intermediaries and requiring compliance by any and all sub-contractors with policy requirements; and conducting required utilization review activities.

(f) Reimbursing subcontracted home care providers; and

(g) Preparing information as required by the Department.

(B) Care Monitoring. Care monitoring are those services provided by a licensed social services or health professional (contracted with or employed by a Home Care Coordinating Agency), to assist a Home Care Coordinating Agency to identify the medical, social, educational, and other needs of an eligible consumer, and facilitate access to needed services. Care monitoring may be provided only to eligible consumers who are receiving or awaiting other authorized HBC services. Care monitoring is provided according to the plan of care authorized by the Assessing Services Agency and implemented by a Home Care Coordinating Agency. The care monitor will complete the following activities and report findings to the Home Care Coordinating Agency based on the task specific authorization:

(1) monitor services delivered;

(2) evaluate the effectiveness of the implementation of the authorized plan of care;

(3) advocate on behalf of the consumer;

(4) counsel the consumer or responsible party about the plan of care authorized by the Assessing Services Agency ;

(5) evaluate the consumer's health status and services needs;

(6) identify gaps in service or care needs;

(7) document and submit to the Home Care Coordinating Agency progress notes that include the outcome of the face-to-face care monitoring; and

(8) make recommendations for any authorized care plan modifications or need for referrals to community resources.

(C) Diagnostic Services. Diagnostic services necessary and not covered by a third party payor, to enhance the authorized plan of care, including independent living evaluation. Venipuncture services may be covered only

as a part of a Registered Nurse authorized service. Venipuncture is not covered as a stand-alone service.

(D) Homemaking Services. Homemaking services means services to assist a consumer with his or her general housework, meal preparation, grocery shopping, laundry, and incidental personal hygiene and dressing. If the consumer is receiving care at Level I, IADL tasks may constitute up to, but shall not exceed, 2 hours per week of authorized services.

(E) Personal Care Services. Personal Care Services consist of personal support services to aid consumers with ADLs and IADLs and Level V medication administration.

(1) Personal support ADL services include bed mobility, transfer, locomotion, eating, toilet use, bathing and personal hygiene, dressing, and health maintenance activities. When authorizing a plan of care that includes personal support services the Assessing Services Agency will use the task time allowances specified in the appendix attached to this section not to exceed limits specified elsewhere in this Section. ADL services may be provided in the consumer's residence or at an adult day services program.

(2) Personal support IADL services include meal preparation, grocery shopping, routine housework and laundry, which are directly related to the consumer's plan of care.

(a) These tasks must be performed in conjunction with personal support ADL services or Level V medication administration services delivered by a Certified Residential Medication Assistant.

(a) These IADL tasks would otherwise be normally performed by the consumer if he or she were physically or cognitively able to do so, and it must be established by the Assessing Services Agency that there is no family member or other person available and willing to assist with these tasks.

(c) If the consumer is receiving care at Level I, IADL tasks may constitute up to, but shall not exceed, 2 hours per week of authorized personal care services.

(d) If the consumer is receiving care at Level II, IADL tasks may constitute up to, but shall not exceed, 3 hours per week of authorized personal support services.

(e) If the consumer is receiving care at Level III, IADL tasks may constitute up to, but shall not exceed, 4 hours per week of authorized personal support services.

(f) If the consumer is receiving care at Level IV, there are no limitations on IADLs, the total monthly cost of services authorized may not exceed the lesser of the cost of the monthly plan of care authorized by the Assessing Services Agency or 80% of the average cost of MaineCare nursing

facility level of care established by the Department.

(g) If the consumer is receiving care at Level V, IADL tasks may constitute up to, but shall not exceed, four (4) hours per week of authorized personal support services.

(h) If the consumer is receiving care at Level V, medication administration may constitute up to, but shall not exceed, three (3) medication pass visits per day for a total of twenty-one (21) medication passes weekly.

(3) All personal support services may be used for ADLs if necessary.

(4) No individual providing this service may be reimbursed for more than 40 hours of care per week for an individual consumer or for a household in which there is more than one consumer.

(5) When authorizing a consumer's plan of care, personal support services for ADLs must be authorized in accordance with the Task Time Allowances not to exceed programs caps or limits specified elsewhere in this section (see appendix to this section). If these times are not sufficient when considered in the light of a consumer's unique circumstances as identified by the authorized agent, the authorized agent may make an appropriate adjustment as long as the authorized hours do not exceed limits established for consumer's level of care. Task time allowances will consider the possibility for concurrent performances of activities and tasks listed. Services listed in the Task Time Allowances that are not covered services under this section may not be authorized.

(6) Except for Level V, a "one Hour" PSS visit. This is a one - hour visit to deliver personal care services and health maintenance activities to a member, no more then once per day. This service may be authorized up to seven days per week. If a person requires more then one hour of personal care service on a given day, then the PSS services must be billed using the half-hour units.

(F) Handyman/Chore Service. Chore services to assist a consumer with occasional heavy-duty cleaning, raising and lowering of combination screen/storm windows, repairs and similar minor tasks to eliminate safety hazards in the environment.

(G) Home Health Services. Home health services to assist a consumer with health and medical and ADL needs as identified on the MED form and authorized by the Assessing Services Agency. These include nursing; home health aide and certified nursing assistant services; physical, occupational, and speech therapy; and medical social services, when no other method of third party payment is available. Home Health services may only be purchased from licensed agencies and shall be reimbursed at an hourly rate. When authorizing personal care services provided by a HHA or CNA, the Assessing Services Agency must use the task time

allowances set forth in the appendix attached to this section to authorize the time covered to complete authorized ADL and IADL tasks for the plan of care not to exceed the program caps or limits specified elsewhere in this section.

(H) Respite. Services provided to individuals, furnished on a short-term basis because of the absence of or need for relief of the caregiver. This service may be provided at home, in a licensed Adult Day Program, or in an institutional setting. An institution is:

(1) An assisted housing program licensed in accordance with 22 MRSA §7851(2) excluding independent housing with services programs;

(2) A nursing facility or unit, licensed in accordance with 22 MRSA §§1811-1824;

(3) An acute care or rehabilitation facility, licensed in accordance with 22 MRSA §§1811-1824; or

(4) A facility for the treatment or management of people who have mental retardation or mental illness.

The annual cost of respite services may not exceed an annual cap as established by the Office of Elder Services and is included in the individual's annual care plan cost limit. A consumer receiving MaineCare Private Duty Nursing/Personal Care Services may receive respite services to the extent that budgeted resources permit and to the extent that there is no waiting list under Section 63.

(I) Transportation. Personal Support Specialists, Certified nursing assistants, home health aides and homemakers may escort or transport a consumer only to carry out the plan of care. Any individual providing transportation must hold a valid State of Maine driver's license for the type of vehicle being operated. All providers of transportation services shall maintain adequate liability insurance coverage for the type of vehicle being operated. Escort services may be provided only when a consumer is unable to be transported alone, there are no other resources (family or friends) available for assistance, and the transportation agency can document that the agency is unable to meet the request for service. Reimbursement shall only be made for mileage in excess of ten (10) miles per single trip on a one-way trip for transportation provided by personal care assistants, homemakers, or other home health providers in the course of delivering a covered service under this section.

(J) Adult Day Services. Adult day services furnished by providers who are licensed and certified by the Department of Human Services.

(K) Mental Health. Mental health services provided by licensed mental health practitioners.

(L) Home Modification. Home modifications necessary to promote independent living and carry out the plan of care up to a life time cost of $3,000, and when there is no alternative source of funding.

(M) Personal Emergency Response System (PERS). A Personal Emergency Response System is an electronic device which enables certain high-risk

~~individuals to secure help in the event of an emergency. PERS services may be provided to those individuals who live alone, or who are alone for significant parts of the day, who are capable of using the system, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.~~

~~63.05 NON COVERED SERVICES~~

~~The following services are not reimbursable under this Section:~~

~~**(A)** Rent and Board~~

~~**(B)** Services for which the cost exceeds the limits described in Section 63.03 and 63.04, except as described in 63.03(A);~~

~~**(C)** Services delivered in a Residential Care facility, a supported living arrangement certified by DHHS for behavioral and developmental services or a licensed or unlicensed Assisted Living Program except for those that meet the definition of a Licensed Assisted Living Agency set forth in Section 63.01(OO);~~

~~**(D)** Services provided by anyone prohibited from employment under the following:~~

~~(1) a personal support specialist or homemaker who is prohibited from employment under Title 22 MRSA §1717(3), §2149-A, §7851, or §8606; or~~

~~(2) a certified nursing assistant who is prohibited from employment under Title 22 MRSA §1812(G).~~

~~**(E)** Homemaker and handyman/chore services not directly related to medical need pursuant to Section 63.04(D) and (F);~~

~~**(F)** Those services which can be reasonably obtained by the consumer by going outside his/her place of residence;~~

~~**(G)** Supervisory visits made for the purpose of supervising home health aides, certified nursing assistants, or personal care assistants; and~~

~~**(H)** Custodial or supervisory care.~~

~~**(I)** Venipuncture is not covered as a stand-alone service.~~

~~63.06 POLICIES AND PROCEDURES~~

~~**(A) Eligibility Determination**~~

~~An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department or the Assessing Services Agency. All other Home Based Care services require eligibility determination and prior authorization by the Assessing Services Agency to determine eligibility pursuant to Section 63.02.~~

~~(1) The Assessing Services Agency will accept verbal or written referral information on each prospective new consumer, to determine appropriateness for an assessment. When funds are available to conduct assessments, appropriate consumers will receive a face to face medical eligibility determination assessment~~

~~at their current residence within the time requirement specified by OES in the contract, of the date of referral to the Assessing Services Agency. All requests for assessments shall be documented indicating the date and time the assessment was requested and all required information provided to complete the request. The individual conducting the assessment shall be a Registered Nurse (RN) and will be trained in conducting assessments and developing an authorized plan of care with the Department's approved MED form. The assessor shall, as appropriate within the exercise of professional judgment, consider documentation, perform observations and conduct interviews with the long-term care consumer, family members, direct care staff, the consumer's physicians and other individuals and document in the record of the assessment all information considered relevant in his or her professional judgment. The RN assessor's findings and scores recorded in the MED form shall be the basis for establishing eligibility for services and the authorized plan of care. The anticipated costs of covered services to be provided under the authorized plan of care must conform to the limits set forth in Section 63.03 (A-F) and 63.04.~~

~~(2) The Assessing Services Agency shall inform the consumer of available community resources and authorize a plan of care that reflects the identified needs documented by scores and timeframes on the MED form, giving consideration to the consumer's living arrangement, informal supports, and services provided by other public and private funding sources. HBC services provided to two or more consumers sharing living arrangements shall be authorized by the Assessing Services Agency with consideration to the economies of scale provided by the group living situation, according to limits in Section 63.03 and 63.04. The Assessing Services Agency shall assign the appropriate level of care for which the consumer is eligible (see Section 63.02) and authorize a plan of care based upon the scores and findings recorded in the MED assessment. The covered services to be provided in accordance with Level I, II, III, IV or V and the authorized plan of care shall: 1) not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the financial caps established by the Office of Elder Services for the corresponding level of care; 2) be prior authorized by the Department or its Assessing Services Agency. The assessor shall approve an eligibility period for the consumer, based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment. An initial eligibility period for Level IV shall not exceed three (3) months.~~

~~(3) The assessor will provide a copy of the authorized plan of care, in a format understandable by the average reader, a copy of the~~

applicable eligibility notice, release of information and the appeal hearing rights notice, to the consumer at the completion of the assessment. The assessor will inform the consumer of the estimated co-payment and the cost of services authorized.

(4) Except for those consumers eligible to receive services under Level V of this Section, the assessor shall forward the completed assessment packet to the Department's authorized Home Care Coordinating Agency within seventy-two (72) hours of the medical eligibility determination and authorization of the plan of care. For those consumers eligible to receive services under Level V of this Section, the assessor shall forward the completed assessment and plan of care to the appropriate Licensed Assisted Living Agency.

(5) For Level I-IV, the Home Care Coordinating Agency shall contact the consumer within the time required under their contract with OES of transmission of the MED assessment and authorized plan of care. The Home Care Coordinating Agency shall assist the consumer with locating providers and obtaining access to services authorized on the careplan summary by the Assessing Services Agency or the Department. The Home Care Coordinating Agency shall implement and coordinate services with the provider agency or independent contractor using service orders, as well as, monitor service utilization and assure compliance with this policy.

(6) For Levels I-IV, the provider or independent contractor shall request through the Home Care Coordinating Agency any change in the authorized plan of care. The Home Care Coordinating Agency shall be responsible to assure that the authorized service plan shall not exceed the lesser of the plan of care authorized by the Assessing Services Agency or the financial cap established by the Department for the level of Home Based Care authorized.

(7) For Levels I-IV, the direct care provider or independent contractor contracted by the Home Care Coordinating Agency to provide skilled nursing services shall develop a nursing plan of care, which shall be reviewed and signed by the recipient's physician. It shall include the personal care and nursing services authorized by the Assessing Services Agency or the Department, and the medical treatment plan signed by the recipient's physician. A copy must be forwarded to the Home Care Coordinating Agency at no additional charge.

(8) For Levels I-IV, the Home Care Coordinating Agency will complete standardized referral requests for reassessment and submit the requests to the Department or the Assessing Services Agency at least five (5) days prior to the reassessment due date. The most up to date status of the consumer as reported by the care coordinator, care monitor and any MDT findings must be included in the reassessment request.

(9) For Level V, the Licensed Assisted Living Agency will complete standardized referral requests for reassessment and submit the requests to the Department or the Assessing Services Agency at least five (5) days prior to the reassessment due date. The most up to date status of the consumer must be included in the reassessment request.

(B) Waiting List

(1) When funds are not available to assess all prospective consumers, the Assessing Services Agency will establish a statewide waiting list for assessments. As funds become available, consumers will be assessed on a first come, first served basis.

(2) For consumers found ineligible for HBC services the Assessing Services Agency will inform each consumer of alternative services or resources, and offer to refer the person to those other services.

(3) When funds are not available to serve new consumers who have been assessed for eligibility or to increase services for current consumers, a waiting list will be established for Levels I-IV by the Home Care Coordinating Agency. For consumers on the wait list, eligibility will be advisory only. As funds become available consumers will be taken off the list and served on a first come, first served basis and eligibility will be determined and a plan of care authorized.

(4) When there is a waiting list, the Home Care Coordinating Agency will inform each consumer who is placed on the waiting list of alternative services or resources, and offer to refer the person to those other services.

(5) The Home Care Coordinating Agency will maintain one statewide waiting list.

(6) Consumer names may be removed from the waiting list at the request of the consumer or if the HCCA determines that another funding source is available to the consumer, or the consumer has entered a hospital, residential care facility or nursing facility for longer than 30 days or upon the death of the consumer.

(C) Suspension Services may be suspended for up to thirty (30) days. If the circumstances requiring suspension extend beyond thirty (30) days, the consumer's eligibility in the program will be terminated. After services are terminated, a consumer will need to be reassessed to determine medical eligibility for services and be subject to the requirements of the waiting list. If the HCCA does not become aware until after 30 days of the

circumstances requiring suspension, the consumer will be terminated as of the date the HCCA verifies the change in status.

(D) Reassessment and Continued Services

(1) For all recipients under this section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and prior authorization of services is required and must be conducted within the timeframe of five (5) days prior to and no later than the reassessment due date. HBC payment ends with the reassessment date, also known as the end date. If the reassessment date for a consumer occurs within the thirty-day suspension period, that reassessment date will be extended for as long as services are suspended, but no later than the last day of the thirty-day suspension period. If services are suspended beyond thirty-days, the consumer's eligibility in the program will be terminated. After services are terminated, a consumer will need to be reassessed to determine medical eligibility for services and will be placed on the waiting list and will be subject to the waiting list requirements.

(2) An individual's specific needs for Home Based Care Services must be reassessed at least every twelve months, or earlier if indicated by the clinical judgment of the nurse assessor;

(3) Unscheduled reassessments due to financial changes that may potentially result in a change in program funding source must be requested by the Home Care Coordinating Agency or the Licensed Assisted Living Agency.

(4) Unscheduled financial reassessments may be completed by the Home Care Coordinating Agency or Licensed Assisted Living Agency when a spouse or significant other household member passes away or there has been a documented change of 20% or greater in the asset or income level of the household;

(5) Unscheduled reassessments due to eligibility or service needs must be justified with consideration given to any MDT findings and requested by the Home Care Coordinating Agency.

(6) Significant change reassessments will be requested by the Home Care Coordinating Agency or the Licensed Assisted Living Agency according to the definition in Section 63.01(JJ). The Assessing Services Agency will review the request and the most recent assessment to determine whether a reassessment is warranted and has the potential to change the level of care or alter the authorized plan of care.

(7) For consumers currently under the appeal process, reassessments will not be conducted unless the consumer experiences a significant change as defined in Section 63.01(JJ) or has an acute or emergency episode as defined in Section 63.01(C).

63.07 Professional and Other Qualified Staff

(A) The Assessing Services Agency and the Home Care Coordinating Agency shall:

(1) Employ staff qualified by training and/or experience to perform assigned tasks and meet the applicable licensure requirements.

(2) Comply with requirements of 22 MRSA §§3471 et seq. and 22 MRSA §§4011-4017 to report any suspicion of abuse, neglect or exploitation.

(3) Pursue other sources of reimbursement for services prior to the authorization of HBC services.

(4) Operate and manage the program in accordance with all requirements established by rule or contract.

(5) Have sufficient financial resources, other than Federal or State funds, available to cover any Home Based Care expenditures that are disallowed as part of the Office of Elder Services utilization review process.

(6) Inform in writing any consumer or any designated representative of a consumer with an unresolved complaint regarding their services about how to contact the Long Term Care Ombudsman.

(7) Assure that costs to HBC funds for services provided to a consumer in a twelve month period do not exceed the applicable annual authorized care plan cost limit, per level of care for which the consumer is determined eligible, established by the Office of Elder Services.

(8) Assure when hiring or contracting for delivery of services that conflict of interest has been disclosed and measures taken to avoid the issue in provision of services. If conflict of interest is identified, document that specific measures have been taken to comply.

(B) The Assessing Services Agency shall:

(1) Implement an internal system to assure the quality and appropriateness of assessments to determine eligibility and authorize care plans including, but not limited to the following:

(a) Consumer satisfaction surveys;

(b) Documentation of all complaints, by any party including resolution action taken;

(c) Measures taken by the Authorized Agent to improve services as identified in (a) and (b).

(2) Consider, as appropriate, any findings of the MDT. The Assessing Services Agency will consider, as appropriate, these findings, when completing the assessment and reassessment in the development of the authorized plan of care that promotes the consumer's independence.

(3) Forward to the Home Care Coordinating Agency or, when appropriate, the Licensed Assisted Living Agency, the completed

assessment, consumer friendly plan of care, signed choice letter and signed release of information. Maintain individual consumer records that include the above items.

C. The Home Care Coordinating Agency shall, for Levels I-IV:

(1) Assure that service providers employed by agencies and independent contractors meet applicable licensure and/or certification and/or training requirements, and maintain records which show entrance and exit times of visits, total hours spent in the home, and tasks completed. Travel time to and from the location of the consumer is excluded.

(2) Maintain annual written agreements with service providers employed by agencies and independent contractors, and communicate current policy or service rate changes to all providers.

(3) Implement an internal system to assure the quality and appropriateness of services delivered including, but not limited to the following:

(a) Consumer satisfaction surveys;

(b) Documentation of all complaints, by any party including resolution action taken;

(c) Measures taken by the Authorized Agent to improve services as identified in (a) and (b).

(4) Include a provision in service provider agreements for reimbursing the Home Care Coordinating Agency if services paid for by HBC are subsequently reimbursed by another payor.

(5) Establish MDT's who will review plans of care, as needed, to identify overlaps of service, over utilization of services or deficits in plans of care. Consider, as appropriate, any findings of the MDT when implementing the authorized plan of care and issuing service authorizations. The RN assessor is considered a member of the MDT

(6) Assure contact with each consumer as required under the contract with OES to verify receipt of authorized services, discuss consumer's status, review any unmet needs and provide appropriate follow-up and referral to community resources.

(7) Employ either directly or through contract face-to-face care monitors and care coordinators who are either a licensed social worker or registered professional nurse with at least one year of community service experience.

(8) Assure that all contracts for personal support services and homemaker services require checks of the CNA registry and any required criminal background checks for all employees prior to the provision of services by the employees of the agency under contract or a Family Provider Service Option memorandum of agreement with the HCCA.

(9) Reimburse providers in accordance with these rules and the HCCA contract with the Department based on the unit of service and rates established by the Department

(10) Recoup funds for services provided if the sub-contracted agency or Family Provider did not provide required documentation to support qualifications of the agency, staff or services billed

(11) Ensure the quality of services and has the authority to determine whether a PCA agency or Family Provider has the capacity to comply with all service requirements. Failure to meet standards must result in no-approval or termination of sub-contracts or memorandums of agreement for PCA services. Termination of a sub-contract cannot be appealed under Section 40.

(12) Contract with a Fiscal Intermediary who agrees to perform employer-related tasks and administrative tasks specified in Section 63.01(S), including but not limited to tasks described in Section 63.07(I).

(D) Registered Professional Nurse

A registered professional nurse employed directly or through a contractual relationship with a home health agency or acting as an individual practitioner may provide services by virtue of possession of a current license to practice their health care discipline in the State in which the services are performed.

(E) Licensed Practical Nurse

A licensed practical nurse employed directly or through a contractual relationship with a home health agency may provide services by virtue of possession of a current license to practice their health care discipline in the State in which the services are performed provided they are supervised by a registered professional nurse.

(F) Home Health Aide

Any home health aide employed by a home health agency must have satisfactorily completed a training program for certified nurse assistants and receive supervision consistent with the rules and regulations of the Maine State Board of Nursing. Home health aides employed by a home health agency must also have satisfactorily completed an agency orientation as defined by the Regulations governing the Licensing and Functioning of Home Health Care Services and be listed on the CNA registry and must not be prohibited from employment under Title 22 MRSA §1812(G).

(G) Certified Nursing Assistant (CNA)

A CNA employed by, or acting under a contractual relationship with, a home health agency must have satisfactorily completed a training program for certified nurse assistants and receive supervision consistent with the Rules and Regulations of the Maine State Board of Nursing and be listed

on the CNA registry and must not be prohibited from employment under Title 22 MRSA §1812(G).

(F) Certified Nursing Assistant/Medications

A CNA who meets the requirements in Section 63.07(G) above and has satisfactorily completed Department-approved medication course for certified Nursing Assistants, consistent with Rules and regulations of the Maine State Board of Nursing and be listed on the CNA registry and must not be prohibited from employment under Title 22 MRSA §1812(G).

(I) Fiscal Intermediary

The FI acts as an agent of the employer in matters related to the employment of personal support specialist and purchase of other support services or goods, including but not limited to carrying out payroll and tax and functions necessary to ensure compliance with federal and state tax and labor laws and program rules.

(J) Social Worker

A social worker must hold a Master's Degree from a school of social work accredited by the Council on Social Work Education, and must be licensed through the Maine Board of Social Worker Registration as documented by written evidence from such Board pursuant to 32 MRSA Chapter 83, and may provide only those services allowed under the scope of that license.

(K) Physical Therapist

A physical therapist must be a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and must be licensed by the State of Maine. A physical therapist may be reimbursed for services provided in his or her own office if the therapist is approved by Medicare pursuant to 42 CFR §405.1730.

(L) Occupational Therapist

An occupational therapist must be licensed to practice occupational therapy by the Maine Board of Occupational Therapy Practice, as documented by written evidence from such Board.

(M) Speech Pathologist

A speech pathologist must be licensed to practice speech pathology by the Maine Board of Examiners on Speech Pathology and Audiology, as documented by written evidence from such Board.

(N) Certified Residential Medication Aide

Certified Residential Medication Aide (CRMAs) are allowed to administer medications to persons served by DHHS Licensed Assisted Living Programs and other licensed facilities only after they have successfully taken a minimal 40-hour class, passed a written test, and demonstrated

~~medication administration competence to an RN. CRMA services are reimbursable under this section only when the CRMA is employed by the Licensed Assisted Living Agency as defined in Section 63.01(OO) and is working under the consultation of an R.N.~~

~~63.08 Consumer Records and Program Reports~~

~~**(A) Content of Consumer Records**. The Home Care Coordinating Agency must establish and maintain a record for each consumer receiving Level I-IV that includes at least:~~

~~(1) The consumer's name, address, mailing address if different, and telephone number;~~

~~(2) The name, address, and telephone number of someone to contact in an emergency;~~

~~(3) Complete medical eligibility determination form and financial assessments and reassessments that include the date they were done and the signature of the person who did them;~~

~~(4) A care plan summary that promotes the consumer's independence, matches needs identified by the scores and timeframes on the MED form and authorized by the Assessing Services Agency, gives consideration of other formal and informal services provided and which is reviewed no less frequently than semiannually. The service plan includes:~~

~~(a) Evidence of the consumer's participation;~~

~~(b) Identification of needs;~~

~~(c) The desired outcome;~~

~~(d) Who will provide what service, when and how often, reimbursed by what funding source, the reason for the service and when it will begin and end; and~~

~~(e) The signature of the nurse assessor who determined eligibility and authorized a plan of care and the Home Care Coordinating Agency staff who authorized the actual service plan.~~

~~(5) A dated release of information signed by the consumer that conforms with applicable state and federal law is renewed annually and that:~~

~~(a) Is in language the consumer can understand;~~

~~(b) Names the agency or person authorized to disclose information;~~

~~(c) Describes the information that may be disclosed;~~

~~(d) Names the person or agency to whom information may be disclosed;~~

~~(e) Describes the purpose for which information may be disclosed; and~~

(f) Shows the date the release will expire.

(6) Documentation that consumers eligible to apply for a waiver for consumer payments, were notified that a waiver may be available;

(7) A copy of the consumer's signed and dated request form authorizing the Home Care Coordinating Agency to arrange services described in the authorized plan of care;

(8) Monthly service orders to providers that specify the tasks to be completed;

(9) Written progress notes that summarize any contacts made with or about the consumer and:

(a) The date the contact was made;

(b) The name and affiliation of the person(s) contacted or discussed;

(c) Any changes needed and the reasons for the changes in the plan of care;

(d) The results of any findings of MDT contacts or meetings; and

(e) The signature and title of the person making the note and the date the entry was made.

(B) Written Progress Notes for Services Delivered by a Direct Care Provider (includes HCCA sub-contracted agencies)

Written progress notes shall contain:

(1) The service provided, date, and by whom;

(2) Entrance and exit times of nurse's, home health aide's, certified nursing assistant's and personal support specialist's visits and total hours spent in the home for each visit. Exclude travel time [unless provided as a service as described in this Section];

(3) A written service plan that shows specific tasks to be completed and the schedule for completion of those tasks;

(4) Progress toward the achievement of long and short range goals. Include explanation when goals are not achieved as expected;

(5) Signature of the service provider; and

(6) Full account of any unusual condition or unexpected event, dated and documented.

(C) **Program Reports**. The following reports must be submitted to Office of Elder Services, in a format approved by the Office of Elder Services, by the day noted:

(1) Monthly service and consumer reports including admissions, discharges and active client lists, due no later than twenty days after the end of the month;
(2) Monthly fiscal reports, due no later than twenty days after the end of the month;
(3) Quarterly and annual demographic reports, due no later than twenty five days after the end of the quarter; and
(4) Monthly authorizations for HBC services, due by the fifth of the month for which authorizations are reported.
(5) Monthly reports of the type and number of assessments completed by the Assessing Services Agency as required by the contract with Office of Elder Services.

63.09 RESPONSIBILITIES OF THE OFFICE OF ELDER SERVICES

(A) Selection of Authorized Agent. To select the Assessing Services Agency and the Home Care Coordination Agency, the Office of Elder Services will request proposals by publishing a notice in Maine's major daily newspapers and posting on the Office of Elder Services website. The notice will summarize the detailed information available in a request for proposals (RFP) packet and will include the name, address, and telephone number of the person from whom a packet and additional information may be obtained. The packet will describe the specifications for the work to be done. Criteria used in selection of the successful bidder or bidders will include but are not necessarily limited to:

(1) Cost;
(2) Organizational capability;
(3) Response to a sample case study;
(4) Qualifications of staff;
(5) References;
(6) Quality assurance plan;
(7) Ability to comply with applicable program policies; and
(8) Demonstrated experience.

(B) Other Responsibilities of the Office of Elder Services. The Office of Elder Services is responsible for:

(1) Setting the annual individual care plan cost limit for each level of care.
(2) Establishing performance standards for contracts with authorized agencies including but not limited to the numbers of consumers to be assessed and served and allowable costs for administration and direct service.
(3) Conducting or arranging for quality assurance reviews that will include record reviews and home visits with HBC consumers.
(4) Providing training and technical assistance.
(5) Providing written notification to the administering agencies regarding strengths, problems, violations, deficiencies or

disallowed costs in the program and requiring action plans for corrections.

(6) Assuring the continuation of services if the Office of Elder Services determines that an Authorized Agent's contract must be terminated.

(7) Administering the program directly in the absence of a suitable Authorized Agent.

(8) Conducting a request for proposals for authorized agents at least every five years thereafter.

(9) At least annually, review randomly selected requests for waivers of consumer payment.

(10) Recouping HBC funds from administering agencies when Office of Elder Services determines that funds have been used in a manner inconsistent with these rules or the Authorized Agent's contract.

63. 10 PERSONAL SUPPORT SERVICES

(A) Scope. This section applies to personal support services provided to consumers of the In-Home and Community Support Services for Elderly and other Adults program by a person who has furnished evidence of competence to carry out the assigned tasks by virtue of previous experience or training. Personal Support Specialist (PSS) is an individual defined in Section 63.01 (FF) who delivers services as defined in Section 63.04(F) of this manual and who meets the training and/or competency requirements described in this Section. A PSS may provide assistance with ADLs and IADLs when they meet the requirements of this Section.

(B) Use of PSS Services.

(1) A PSS may be used when the ADL needs of the consumer can be met with this level of service provider;

(2) Family and household members providing PSS services and seeking payment by the program must comply with the training and/or competency requirements of this section unless exempted under this section;

(3) The PSS shall perform tasks that are consistent with the Assessing Services Agency authorized plan of care and, for Levels I-IV, the Home Care Coordinating Agency service authorization;

(4) With the exception of Family Providers who are consumers managing their own care, PSS employed by agencies must receive on-site supervision by their employer as described in Section 63.10(E)(5);

(5) The consumer and/or family has the right to request a change in personal support specialist. If it is not possible for the consumer and the agency together to resolve the issues that have caused the

consumer to request a change, the agency will make the change, if alternate staff are available.

(C) Family Provider Service Option (FPSO) is a service provision option that allows an adult, twenty- one years or older, to register as a Personal Care Agency solely for the purpose of managing his or her own services or solely for managing the services of no more than two of his/her family members. For purposes of this definition only, family members include individuals related by blood, marriage or adoption as well as two unmarried adults who are domiciled together under a long-term arrangement that evidences a commitment to remain responsible indefinitely for each other's welfare. Unless specifically exempted in this subsection or elsewhere in Section 63, all other requirements of Section 63 apply to the Family Provider Service option. This is not a service option under Level V of this Section.

(1) The following requirements apply to the Family Provider Service Option:

(a) The consumer who chooses to manage his or her own services must meet the cognitive capacity as defined in 63.01 (J).

(b) The consumer or family member must register as a personal care agency (the "Family Provider") with the Department of Health and Human Services pursuant to Title 22 MRSA §1717. A consumer who does not meet the cognitive capacity as defined in 63.01(J) is not permitted under this section to register as a personal care agency;

(c) The Family Provider must conduct a criminal history background check if required by Title 22 MRSA §1717 for any individual hired as a personal support specialist and also must check the Certified Nursing

Assistant Registry; and not employ an individual who is prohibited from employment under Title 22 MRSA §1717(3);

(d) The Family Provider must document the following in a Personal Support Specialist's personnel record:

(i) evidence of the competence of the PSS in all required tasks, including the scope of the demonstration and the signature of the individual certifying competency; and

(ii) evidence of orientation adequate to meet the consumer's needs.

(iii) evidence of a Certified Nursing Assistant Registry check and, if required by Title 22 MRSA §1717(3), a criminal history background check.

(e) The adult who is registered as the agency may not be paid to provide care to the consumer;

(f) A consumer's guardian may not be paid to provide care to the consumer;

(g) Family Provider must use a Fiscal Intermediary as a payroll agent approved by the HCCA; and

(h) Failure by the Family Provider to comply with the HCCA memorandum of agreement requirements shall result in a termination of the agreement with the HCCA.

(2) As part of the Family Provider Services Option, the Home Care Coordinating Agency (HCCA) shall:

(a) check the CNA Registry and conduct a criminal background check on the individual who registers as a personal care agency

(b) establish a monthly cost limit based on the authorized plan of care;

(c) manage professional and/or covered services (RN, ERS for example), other than personal support services; if requested by the consumer or family provider,

(d) contract with a Fiscal Intermediary (FI); and

(e) recoup funds for services delivered in non-compliance with this section.

(D) Training and Competency. With the exception of PSSs providing PSS services under the Family Provider Service Option, to be reimbursed, PSSs must meet the requirements of this subsection. To meet training requirements, a PSS must:

(1) Currently be listed on the Certified Nursing Assistant's registry.

(a) CNAs who lapse their registry status due to a non-completion of the required employment in a health care institution, may choose to take the competency-based examination of didactic and demonstrated skills from OES approved curriculum. Successful passing of this examination will result in a certificate of training as a Personal Support Specialist.

(b) If the competency-based examination is not completed successfully the CNA must complete the training requirements outline in Section D (3); or

(2) Provide evidence of satisfactory completion of a basic nurse's aide or home health aide training program meeting the standards of the Maine State Board of Nursing within the past three (3) years.

(a) The applicants may choose to take the competency-based examination of didactic and demonstrated skills from OES approved curriculum. Successful passing of this examination will result in a certificate of training as a Personal Support Specialist.

(b) Applicants who have completed a basic nurse's aide course or home health aide training program outside the past three years may choose to take the competency-based examination of didactic and demonstrated skills from any OES approved curriculum. Successful passing of this examination will result in a certificate of training as a Personal Support Specialist.

(c) If the competency-based examination is not completed successfully, the applicant must complete the training requirements outlined in Section D (3) or;

(3) Provide evidence of satisfactory completion of a Department approved training course. The training shall meet the following conditions:

(a) The course must include at least 50 hours of formal classroom instruction, demonstration, return demonstration, and examination and must cover the tasks included in Section 63.01(FF); and

(b) Provide evidence of successful passing of a competency-based examination of didactic and demonstrated skills resulting in a certificate of training as a Personal Support Specialist.

(4) PSSs must complete the training and examination within six (6) months of employment.

(a) A newly hired PSS who does not yet meet the Department's training and examination requirements must undergo an eight (8) hour orientation by the employing agency that reviews the role and responsibilities of a PSS.

(b) The orientation must be completed before the PSS starts delivering services to consumers.

(c) The PSS must demonstrate competency in all required tasks prior to being assigned to a consumer's home. Demonstration of competency must be documented in the employee's record and include the scope of the

demonstration and the signature of the individual certifying competency.

(d) PSSs newly hired to an agency, who meet the Department's training and/or certification requirements, must receive an agency orientation. The training and certification document must be on file in the individual's personnel record.

(e) When the nature of the tasks or the condition of the consumer warrant the specialized knowledge and skills of a health professional, as determined by the medical eligibility assessment, the PSS shall be trained by the health professional and satisfactorily demonstrate the skill to carry out the necessary tasks.

(5) Exemptions

Personal Support Specialists (PSSs) who received and successfully completed a OES approved curriculum prior to 9/1/03, will be grandfathered and allowed to continue to provide home care services as a Personal Support Specialist (PSS).

(E) Employment or Provider Agency Responsibilities.

(1) Providers, other than those in the Family Provider Service Option, employing Personal Support Specialists (PSSs) must assure that all PSSs meet the applicable training and competency requirements 63.10(D). The responsibility for verification of PSS credentials rests with the employer. The employer must maintain a personnel record for each PSS which must include:

(a) evidence of the competency of the PSS in all required tasks, including the scope of the demonstration and the signature of the individual certifying the competency of the PSS to meet each consumer's needs; and

(b) evidence of the eight (8) hour orientation which reviews the role and responsibilities of a PSS; and the certificate of training.

(c) evidence of a Certified Nursing Assistant Registry check and of a criminal history background check, if required by Title 22 MRSA §1717(3).

(2) Providers employing PSSs, CNA, Home Health Aides or homemakers working as Personal Support Specialist must check the CNA Registry and, if required by Title 22 MRSA §1717(3), complete a criminal background check, and may not employ an individual as a personal support specialist who is prohibited from employment under Title 22 MRSA §1717(3).

(3) Providers must develop and implement personnel policies which insure a smoke free environment. PSSs are not allowed to smoke, use alcohol or controlled substances in the consumer's home or vehicle during work hours.

(4) With the exception of Family Service Providers who are consumers managing their own care, a visit shall be made in a consumer's home by a supervisor or Agency representative prior to the start of PSS services to develop and review with the consumer the plan of care as authorized by the Assessing Services Agency on the care plan summary and by the Home Care Coordinating Agency on the service order.

(5) Supervisory visits: With the exception of Family Service Providers who are consumers managing their own care, for Level III and IV PSSs employed by agencies must receive on-site supervision of the implementation of the Level III and Level IV consumer's authorized plan of care by their employer at least quarterly to verify consumer satisfaction with the PSS performance in meeting the care plan tasks. For Level I and Level II consumers, on-site supervision must be at least once every six months with quarterly phone calls to the consumer. Direct on site supervision of the PSS, outside of the plan of care implementation and consumer satisfaction mentioned above, is up to the discretion of the provider agency and their personnel policies and procedures.

(6) PSS agencies operated by consumers or family members must agree to on-site home supervisory visits by the HCCA to evaluate the condition of the consumer, implementation of the care plan, and whether the services are satisfactory to the consumer and the HCCA. Failure to allow the HCCA on-site visits is grounds for terminating reimbursement to the PCA PSS worker or the PSS worker or terminating the contract with the agency.

(7) Maintenance of consumer records:

(a) A written service plan that shows specific tasks to be completed and schedule for completion of those tasks;

(b) Documentation which shows the entrance and exit times of PSS visits and total time spent in the home;

(c) The name and telephone number of the person to call in case of an emergency or other needed information.

63.11 Consumer Payments

(A) Consumer Payments. The administering agency will use an Office of Elder Services approved form to determine the client's income and liquid assets and calculate the monthly payment to be made by the consumer. The agency may require the consumer and his or her spouse to produce

documentation of income and liquid assets. A consumer need not complete a financial assessment if he or she pays the full cost of services received. His or her payments, as determined by an annual financial assessment may not exceed the total cost of services provided. For Level I-IV, the final consumer payment will be determined by the HCCA. For Level V, the final consumer payment will be determined by the Licensed Assisted Living Agency.

(B) Definitions. The following definitions apply to this Section.

(1) Dependent allowances. Dependents and dependent allowances are defined and determined in agreement with the method used in MaineCare. The allowances are changed periodically and cited in the MaineCare Benefits Manual, TANF Standard of Need Chart. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.

(2) Disability-related expenses: Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:

(a) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening, environmental controls;

(b) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response Systems;

(c) Wheelchair (manual or power) accessories: lap tray, seats and back supports;

(d) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;

(e) Hearing Aids, glasses, adapted visual aids;

(f) Assistive animals (purchase only);

(g) Physician ordered medical services and supplies;

(h) Physician ordered prescription and over the counter drugs; and

(i) Medical insurance premiums, co-pays and deductibles.

(3) Household members: means the consumer and spouse.

(4) Household members' income includes:

~~**(a)** Wages from work, excluding state and Federal taxes and employer mandated or court ordered withholdings;~~

~~**(b)** Benefits from Social Security, Supplemental Security Income, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;~~

~~**(c)** Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax;~~

~~**(d)** Interest and dividends.~~

~~**(e)** Regularly occurring payments received from a home equity conversion mortgage.~~

~~Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.~~

~~**(5)** A **liquid asset** is something of value available to the consumer that can be converted to cash in three months or less and includes:~~

~~**(a)** Bank accounts;~~

~~**(b)** Certificates of deposit;~~

~~**(c)** Money market and mutual funds;~~

~~**(d)** Life insurance policies;~~

~~**(e)** Stocks and bonds;~~

~~**(f)** Lump sum payments and inheritances; and~~

~~**(g)** Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form.~~

~~Funds which are available to the consumer but which carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.~~

~~**(C) Consumer Payment Formula.** The provider agency will use the following formula to determine the amount of each consumer's payment.~~

~~**Step (1)** - Calculate the Monthly Contribution from Income.~~

~~**(a)** Total the monthly income of the consumer and spouse.~~

(b) Deduct monthly allowable disability related expenses.

(c) Deduct monthly allowable dependent allowances.

(d) Multiply the net income by 4%.

Step (2) - Calculate the Monthly Contribution from Liquid Assets.

(a) Total the liquid assets of the household members.

(b) Deduct annual interest and annual dividends counted towards income for the household.

(c) Subtract $15,000 from the amount of liquid assets calculated in Step (2)(a&b). If the result is less than zero use zero.

(d) Multiply the sum calculated in Step (2)(c) by 3%. The result is the Monthly Contribution from Liquid Assets

Step (3) - Add the result of the calculation in Step (1)(d) to the result of the calculation in Step (2)(d).

Step (4) - The consumer's monthly payment is the lesser of the sum calculated in Step (3) or the actual cost of services provided during the month.

Step (5) - When two persons in a household are both receiving Home Based Care services under this program, collect the required information for each person. Calculate the co-pay for each consumer and combine the total. Divide the amount by two to determine the household monthly co-payment.

(D) Waiver of Consumer Payment. Consumers will be informed that they may apply for a waiver of all or part of the assessed payment when:

(1) Monthly income of household members is no more than 200% of the federal poverty level; and

(2) Household assets are no more than $15,000.

63.12 Method for Reviewing Requests for Waivers of Consumer Payment

(A) Consumers requesting waivers may be asked to provide verification of any income, liquid assets and expenses for housing, transportation, unreimbursed medical expenses, food, clothing, laundry and insurance.

(B) Consumers may request a waiver from the Home Care Coordinating Agency or the Licensed Assisted Living Agency of all or part of the assessed payment.

(1) The request must be submitted in writing:

~~**(a)** within ten (10) days of the date of notification of the assessed consumer payment, or~~

~~**(b)** within ten (10) days of the date of their last functional reassessment, or~~

~~**(c)** within ten (10) days of the date the consumer began to receive services after being on the waiting list.~~

~~**(2)** Requests for waiver must be on a form approved by the Office of Elder Services.~~

~~**(3)** The administering agency will act on the request and inform the consumer of its decision in writing within twenty (20) days of receipt of the request.~~

~~**(4)** If the administering agency needs additional information, in order to determine whether the waiver can be granted, the administering agency will promptly notify the consumer. The consumer must submit the additional information within ten (10) days. In such cases the agency will issue its decision within ten (10) days of receipt of the additional information.~~

~~**(C)** A consumer who is otherwise eligible may receive services while awaiting the agency's decision on the request for waiver. The agency will hold the consumer payment in abeyance pending a decision on the request, or the completion of the appeals process, whichever is later~~

~~**(D)** The agency will inform the consumer in writing if the request for a waiver is approved or denied. If denied, the agency's notice must include information on appeal rights.~~

~~**(E)** If the waiver is denied, the consumer payment, including payments held in abeyance, is due within thirty (30) days of the date of the decision, or services will be terminated.~~

~~**(F)** When allowable expenses plus the consumer payment exceed the sum of monthly income plus the Monthly Contribution From Liquid Assets, the agency will waive the portion of the payment that causes expenses to exceed income.~~

~~**(G)** Consumers who have applied for a full or partial waiver of the assessed payment and been denied may reapply only if one of the following conditions exists and is expected to continue until the next regularly scheduled financial assessment:~~

~~**(1)** the consumer has at least a 20% decrease in monthly income or liquid assets.~~

~~**(2)** the consumer has an increase in expenses which results in the sum of the allowable expenses plus the consumer payment exceeding monthly income plus the Monthly Contribution From Liquid Assets.~~

(H) Expenses. Expenses will be reduced by the value of any benefit received from any source that pays some or all of the expense. Examples include but are not limited to, Medicare, MaineCare, Food Stamps and Property Tax and Rent Refund. Business expenses that exceed business income are not allowable. Allowable expenses include actual monthly costs of all household members for:

(1) housing expenses which include and are limited to` rent, mortgage payments, property taxes, home insurance, heating, water and sewer, snow and trash removal, lawn mowing, utilities and necessary repairs;

(2) food, clothing and laundry not to exceed;

Monthly Allowance for Food, Clothing and Laundry

Number in Household	**1**	**2**	**3**	**4**	**5 & up**
Amount	$217	$343	$459	$577	$694

(3) transportation expenses which include and are limited to ferry or boat fees, car payments, car insurance, gas, repairs, bus, car and taxi fare;

(4) unreimbursed medical expenses including but not necessarily limited to health insurance; prescription or physician ordered drugs, equipment and supplies; and doctor, dentist and hospital bills;

(5) life insurance;

(6) limited discretionary expenses;

The following chart shows maximum allowable discretionary expenses by household size. Amounts in excess of the monthly allowance may not be claimed.

Maximum Allowable Discretionary Expenses

Number in Household	**1**	**2**	**3**	**4**	**5 & up**
Amount	$76	$120	$161	$203	$244

APPENDIX TO SEC 63 TASK TIME ALLOWANCES – ACTIVITIES OF DAILY LIVING

ACTIVITY	DEFINITIONS	TIME ESTIMATES	CONSIDERATIONS
BED MOBILITY	HOW PERSON MOVES TO AND FROM LYING POSITION, TURNS SIDE TO SIDE AND POSITIONS BODY WHILE IN BED.	5 – 10 MINUTES	Positioning supports, cognition, pain, disability level.

TRANSFER	HOW PERSON MOVES BETWEEN SURFACES – TO/FROM: BED, CHAIR, WHEELCHAIR, STANDING POSITION (EXCLUDE TO/FROM BATH/TOILET).	5 – 10 MINUTES **up to 15 minutes**	Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition **Mechanical Lift transfer**
LOCOMOTION	HOW PERSON MOVES BETWEEN LOCATIONS IN HIS/HER ROOM AND OTHER AREAS ON SAME FLOOR. IF IN WHEELCHAIR, SELF-SUFFICIENCY ONCE IN CHAIR.	5 – 15 MINUTES (DOCUMENT TIME AND NUMBER OF TIMES DONE DURING POC)	Disability level, Type of aids used or Pain
DRESSING & UNDRESSING	HOW PERSON PUTS ON, FASTENS AND TAKES OFF ALL ITEMS OF STREET CLOTHING, INCLUDING DONNING/REMOVING PROSTHESIS.	20 – 45 MINUTES	Supervision, disability, pain, cognition, type of clothing, type of prosthesis.
EATING	HOW PERSON EATS AND DRINKS (REGARDLESS OF SKILL)	5 minutes	Set up, cut food and place utensils.
		30 minutes	Individual is fed.
		30 minutes	Supervision of activity due to swallowing, chewing,
TOILET USE	HOW PERSON USES THE TOILET ROOM (OR COMMODE, BEDPAN, URINAL); TRANSFERS ON/OFF TOILET, CLEANSES, CHANGES PAD, MANAGES OSTOMY OR CATHETER AND ADJUSTS CLOTHES.	5–15 MINUTES/USE	Bowel, bladder program Ostomy regimen Catheter regimen cognition
PERSONAL HYGIENE	HOW PERSON MAINTAINS PERSONAL HYGIENE. (EXCLUDE BATHS AND SHOWERS)	WASHING FACE, HANDS, PERINEUM, COMBING HAIR, SHAVING AND BRUSHING TEETH — 20 MIN/DAY	DISABILITY LEVEL, PAIN, COGNITION, ADAPTIVE EQUIPMENT.
		Shampoo (only if done separately) — 15 min up to 3 times/ week	
		NAIL CARE — 20 MIN/WEEK	
WALKING	a. HOW PERSON WALKS FOR EXERCISE ONLY b. How person walks around own room c. How person walks within home d. How person walks outside	DOCUMENT TIME AND NUMBER OF TIMES IN POC, AND LEVEL OF ASSIST IS NEEDED.	DISABILITY COGNITION PAIN MODE OF AMBULATION (CANE) Prosthesis needed for walking
BATHING	HOW PERSON TAKES FULL BODY BATH/SHOWER, SPONGE BATH (EXCLUDE WASHING OF BACK, HAIR), AND TRANSFERS IN/OUT OF TUB/SHOWER	15 – 30 MINUTES	If shower used and shampoo done then consider as part of activity, cognition.

~~State of Maine~~

~~14~~

~~DEPARTMENT OF HEALTH AND HUMAN SERVICES~~

~~197~~

~~Chapter 11~~

~~Rules Governing~~

~~Consumer Directed Personal Assistance Services~~

~~Effective Date:~~
~~October 8, 2007~~

Maine Department of Health and Human Services

Consumer-Directed Personal Assistance Services

Table of Contents

Section

~~14-197~~

~~DEPARTMENT OF HEALTH AND HUMAN SERVICES~~

~~CHAPTER 11. CONSUMER-DIRECTED PERSONAL ASSISTANCE SERVICES~~

~~**PREAMBLE:** These regulations are promulgated pursuant to 34-B M.R.S.A. §5438, relating to a program of Consumer-Directed Personal Assistance Services. It is the purpose of the Consumer-Directed Personal Assistance Services program to provide services, subject to the availability of funds, for adult Maine residents with severe disabilities that allow them to remain in their homes and communities and out of institutional settings. The Department of Health and Human Services will regularly assess the resources available to administer the program and establish Maximum Authorized Service amounts as needed to operate within available funding. This program will strive to promote consumer choice, consumer direction, flexibility, as well as consumer responsibility in the provision of these services.~~

~~11.01 DEFINITIONS~~

~~**(A) Consumer-Directed Personal Assistance Services** program, hereinafter referred to as **Consumer-Directed Home Based Care (CDHBC),** is a state funded program to provide long term care services to assist eligible consumers to avoid or delay inappropriate institutionalization. State funds furnished through 34-B M.R.S.A. §5438 may not be used to supplant the resources available from families, neighbors, agencies and/or the consumer or from other Federal, State programs unless specifically provided for elsewhere in this section. State CDHBC funds shall be used to purchase only those covered services that are essential to assist the consumer to avoid or delay inappropriate institutionalization and which will foster independence, consistent with the consumer's circumstances and the authorized plan of service.~~

~~**(B) Activities of daily living (ADLs)** ADLs include the following as defined in Section 11.02(B)(1)(a): bed mobility, transfer, locomotion, eating, toileting, bathing, hygiene, and dressing. The list of ADLs may be modified by the Authorized Agent, with the approval of the Department.~~

~~**(C) Assessing Services Agency (ASA)** ASA means an organization authorized through a written agreement with the Department to conduct face-to-face assessments, using the Department's Medical Eligibility Determination (MED) form, and the timeframes and~~

definitions contained therein, to determine medical eligibility and need for covered services. Based upon a consumer's assessment outcome scores recorded in the MED form, the ASA is responsible for authorizing a plan of service, which shall specify all services to be provided under this Section, including the number of hours for services, and the Authorized Agent types. The ASA is the Department's Authorized Agent for medical eligibility determinations and service plan development, and authorization of covered services as allowed under this Section.

(D) Authorized Agent means an organization authorized by the Department under a valid contract or other approved, signed agreement to conduct a range of activities, which includes some or all of the following: accept referrals; assess consumer service needs; monitor the implementation of the service plan; train the consumer; serve as a resource to consumers and their families; and assist with resolving problems. The Authorized Agent is also responsible for administrative functions, including maintaining consumer records; processing claims; final determination of the consumer copayment on receipt of the required information and collection of consumer co-payments; conducting the functions of an employer of record; and conducting required utilization review activities.

(E) Authorized Plan of Service is a plan of service that is determined by the Assessing Services Agency, or the Department, and that specifies all services to be delivered to a consumer as allowed under this Section, including the number of hours for all covered services under this section. The Authorized Plan of Service shall be based upon the consumer's assessment outcome scores, and the timeframes contained therein, recorded in the Department's medical eligibility determination (MED) form. The Authorized Plan of Service must be completed on the Department's MED form and must not exceed the services required to provide necessary assistance with ADLs, IADLs, and identified Health Maintenance Activities on the MED form. The Authorized Agent has the authority to determine and authorize the plan of service. All authorized covered services provided under this Section must be listed in service Plan summary on the MED form. The Authorized Plan of Service must reflect the needs identified by the assessment, giving consideration to the consumer's living arrangement, informal supports, and services provided by other possible public or private funding sources to ensure non duplication of services. In no case will the amount of service authorized exceed the Maximum Authorized Service amount established by the Department. In the event the Maximum Authorized Service

~~amount is amended, all Authorized Plans of Service will immediately be amended to reflect the amended Maximum.~~

~~**(F) Department** means the Department of Health and Human Services.~~

~~**(G) Service Plan Summary** is the section of the MED form that documents the Authorized Plan of Service and services provided by other public or private program funding sources or support, service category, reason codes, duration, unit code, number of units per month, rate per unit, and total cost per month.~~

(H) Cognitive capacity: The consumer must have the cognitive capacity to perform all of the tasks and responsibilities of an employer in order to competently direct and manage the assistant. The consumer's cognitive capacity will be determined by an assessment conducted by the Authorized Agent.

(I) Complete Medical Eligibility Determination packet includes a signed release of information, the fully completed medical eligibility determination (MED) form, the eligibility notification, hearing and appeal rights, service plan, complete financial assessment. Packets submitted that do not meet Department specifications will be returned to the AA.

(J) Consumer, is the individual qualified for the program who will direct and control the Personal Assistant (PA). The consumer is someone with a disability who has functional limitations, which interfere with self-care and activities of daily living. The consumer must have the cognitive capacity to competently direct and manage the assistant on the job in order to assist and/or perform the ADLs, IADLs, and health maintenance activities. The consumer must be determined eligible for services under this section.

(K) Consumer-Directed Home Based Care Services, also known as Personal Assistance Services (PAS), or Assistance Services, enable eligible people with disabilities to re-enter or remain in the community and to maximize their independent living opportunity at home. Consumer Directed Home Based Care Services includes a range of assistance with Activities of Daily Living (ADL), Instrumental Activities of Daily Living and Health Maintenance activities. The eligible consumer hires his/her own assistant, trains the assistant, supervises the provision of covered services, completes the necessary written documentation, and if necessary, terminates services or directs the termination of the assistant. The Department or the Assessing Services Agency, consistent with these rules, shall determine medical eligibility for services under this Section, prior authorize all covered services as allowed under this section, and authorize a plan of service for each new and established consumer of services.

(L) Covered Services are those services for which payment can be made by the Department, under these regulations.

(M) Criminal Background Check is research into the history of a PA or potential PA to determine if there is any criminal conviction involving abuse, neglect or misappropriation of property in a health care setting, or a complaint involving abuse or neglect that was substantiated by the Department pursuant to its responsibility to license hospitals, nursing facilities, home health agencies and assisted housing programs and that was entered on the Maine Registry of Certified Nursing Assistants, or a complaint involving the misappropriation of property in a health care setting that was substantiated by the Department and entered on the Maine Registry of Certified Nursing Assistants.

(N) Department means the Maine Department of Health and Human Services.

(O) Dependent Allowances. Dependents and dependent allowances are defined and determined in agreement with the method used in the MaineCare program. The allowances are changed periodically and cited in the MaineCare Eligibility Manual, Chart II, AFDC Related Income Limits. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.

(P) Disability-related expenses: Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:

(1) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening, environmental controls;
(2) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response Systems;
(3) Wheelchair (manual or power) accessories: lap tray, seats and back supports;
(4) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;
(5) Hearing Aids, glasses, adapted visual aids;
(6) Assistive animals (purchase only);

(7) Physician ordered medical services and supplies;
(8) Physician ordered prescription and over the counter drugs;
(9) Medical insurance premiums, co-pays and deductibles;
(10) Unemployment and workers compensation expenses related to employing the PA; and
(11) The actual paid costs of conducting criminal background checks

(Q) Extensive Assistance means although the individual performed part of the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was required and provided:
(1) Weight bearing support three or more times, or
(2) Full staff performance during part (but not all) of the last 7 days.

(R) Health Maintenance Activities are those activities designed to assist the consumer with ADLs and IADLs and additional activities as specified in the definition. These activities are performed by a designated individual who provides formal and informal supports for a competent self-directing individual, who would otherwise perform the activities, if he or she were physically able to do so and enable the individual to live in his or her own home and community. These additional activities include catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, ventilator care, occupational and physical therapy activities such as assistance with prescribed exercise regimes.

(S) Income includes:
(1) Wages from work, including payroll deductions, excluding state and Federal taxes and employer mandated or court ordered withholdings;
(2) Benefits from Social Security, Supplemental Security Income (SSI), Social security Disability Insurance (SSDI), pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;
(3) Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax; and
(4) Interest and dividends.

Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.

(T) Instrumental activities of daily living (IADLs) Instrumental Activities of Daily Living (IADL); For purposes of the eligibility criteria and covered services under this section of policy, IADLs are limited to the following: meal preparation: preparation or receipt of the meal; routine housework; grocery shopping, storage of purchased groceries; community access; and laundry either within the residence or at an outside laundry facility; and money management, as directed by the consumer, for the consumer. The list of IADLs may be modified by the Authorized Agent, with the approval of the Department.

(U) Limited Assistance means the individual was highly involved in the activity over the past seven days, or 24 to 48 hours if in a hospital setting, but received and required guided maneuvering of limbs or other non-weight bearing physical assistance three or more times or with weight-bearing support one or two times.

(V) Liquid asset is something of value available to the consumer that can be converted to cash in three months or less and includes:

(1) Bank accounts;
(2) Certificates of deposit;
(3) Money market and mutual funds;
(4) Cash value of life insurance policies;
(5) Stocks and bonds; and
(6) Lump sum payments and inheritances.
(7) Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form.

Funds which are available to the consumer but carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.

(W) Maximum Authorized Service is the highest number of day and night hours of service available to a Consumer as currently established by the Department of Health and Human Services. In establishing these limits, the Department will consult with the members of its Quality Assurance Review Committee. The Maximum Authorized Service amount must be determined at a rate

that will allow the program to operate through the end of the current budget period within available resources.

(X) Personal Assistance Needs are those determined as a result of completion of the medical eligibility determination form, resulting from an individual's inability to manage ADLs and IADLs, as a result of physical, emotional, or developmental problems.

(Y) Medical Eligibility Determination (MED) Form is the form approved by the Department for medical eligibility determinations and service authorization for the Authorized Plan of Service based upon the assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form are contained therein and provide the basis for services and the service plan authorized. The service plan summary contained in the MED form documents the Authorized Plan of Service approved by the Authorized Agent. It also includes the service category, reason codes, duration, unit codes, number of units per month and rate per unit.

(Z) Multi-disciplinary team (MDT). The MDT includes the consumer, the Authorized Agency, designated Registered Nurse (RN), Occupational Therapist (OT), or Certified Occupational Therapy Aid (COTA) staff, and may also include other people who provide or have an interest in the consumer's well-being.

(AA) One-person Physical Assist requires one person over last seven (7) days or 24-48 hours if in a hospital setting, to provide either weight-bearing or non-weight bearing assistance for an individual who cannot perform the activity independently. This does not include cueing.

(BB) Personal Assistance Services are services provided by a personal assistant (PA), which are required by an adult with personal care needs to achieve greater physical independence, which are consumer directed and which are limited to assistance with:

(1) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

(2) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

(3) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

(4) Eating: How person eats and drinks (regardless or skill);

(5) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
(6) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower;
(7) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing.
(8) Hygiene: How person combs hair, brushes teeth, shaves, applies make-up, and washes and dries one's face and perineum.

(CC) Personal Assistant is an individual who provides support to a consumer as in (BB) above.

(DD) Quality assurance review committee (QARC) is a group appointed by the Department of Health and Human Services, whose responsibility it is to make recommendations to the Department for policy changes and improving quality of care and outcomes for the consumer.

(EE) Self-Direct means the consumer hires, trains, directs assistants, and when necessary terminates the assistant. The applicant's ability to self-direct must be documented on the Medical Eligibility Determination Form.

(FF) Service Plan is the document used by the Authorized Agency to assist the consumer to direct their assistant services as specified in the authorized plan of service. The Department must approve the service plan in template form. The plan must outline the ADL and IADL tasks, the time required to complete the tasks, and the frequency of the tasks that will be the basis for the assistant's job description and weekly schedule. The service plan will show the total hours available each week for the consumer to manage and direct the assistant. The hours shall not exceed the hours authorized on the MED form service plan summary or the Maximum Authorized Service amount, whichever is lesser and must include only the covered services from Section 11.04. The service plan is prepared after and is based on the completed MED form.

(GG) Significant change. A significant change is defined as a major change in the consumer's status that, impacts on one or more areas of their functional or health status, and requires review or revision of the plan of service. A significant change assessment is appropriate if there is a consistent pattern of changes, with either

two or more areas of improvement, or two or more areas of decline, that requires a review of the service plan and potential for a level of care change.

(HH) Total Dependence means full staff performance of the activity during the last seven (7) day period across all shifts, or during each eight (8) hour period in the twenty-four (24) hours.

11.02 ELIGIBILITY FOR SERVICES

(A) General and Specific Requirements. To be eligible for services a consumer must:

(1) Be at least 18;

(2) Live in Maine; "Live in Maine" means to have legal residence in Maine and be present in Maine for 183 days of the year, except for Maine resident students attending school. Consumers relocating may be allowed up to one month's program services to assist the consumer to make a transition to other services;

(3) Lack sufficient personal and/or financial resources for in-home services;

(4) Be ineligible for the MaineCare Private Duty Nursing Personal Assistance Services, MaineCare Adult Day Health, MaineCare Consumer Directed Assistant Services programs. Consumers who are eligible for the MaineCare Home and Community Based Waiver program may be deemed eligible for supplemental funds under this program, subject to availability of funds;

(5) Not be residing in a hospital or nursing facility;

(6) Agree to pay the monthly calculated consumer payment. This payment may be subsequently waived or reduced if the consumer's application for a waiver or reduction is approved.

(7) Not have a guardian or a conservator:

(8) Eligibility for the Consumer Directed HBC Program requires a significant level of skill and responsibility from the consumer. In order to be eligible for CDHBC services, a consumer must be capable of performing all the tasks and responsibilities of an employer. In order to best determine the applicant's ability to function in this role, the Authorized Agent will assess the individual's cognitive abilities as follows:

(A) Based on actual performance during skills training. The assessor will review the consumer's ability to understand and retain the elements included in the regular course of consumer skills training.

(B) In actual performance as a consumer of program services. During the course of using program services, and

particularly during the first year of service, the Authorized Agent will continually assess the consumer's ability to successfully participate in the Program. Included in skills training will be:

(1) Understanding of the consumer's disability, including health issues and relevant adaptive equipment and ability to explain disability to others;
(2) Ability to understand and communicate assistance needs;
(3) Ability to understand and communicate safe and unsafe conditions;
(4) Ability to handle finances associated with the program;
(5) Ability to communicate effectively in writing, verbally or using adaptive equipment;
(6) Demonstrated ability to direct others as needed in an employment relationship;
(7) Ability to create and carry out daily work plans for PAs;
(8) Understanding of local resources and ability to self refer for needed services;
(9) Demonstrated ability to create and carry out a hire plan for PAs;
(10) Ability to train and supervise PAs;
(11) Ability to retain PAs as employees;
(12) Ability to successfully carry out the responsibilities of program consumers as specified in the Department's rules;
(13) Demonstrated understanding of HIPAA confidentiality requirements.

At any point during the initial evaluation, or in the course of ongoing service, that the Authorized Agent determines the consumer is unable to carry out the requirements of this section, the consumer will be found ineligible for the program.

(9) The individual must agree to undergo consumer instruction and testing within thirty (30) days of the assessment in order to develop and verify that they have attained the skills needed to hire, train, schedule, supervise, and document the provision of Personal Assistance Services identified in the authorized plan of service. Consumers who do not complete the instruction or do not demonstrate to the Authorized Agent that they have attained the skills needed to hire, fire, train, schedule, supervise and document

the delivery of their identified care services, are not eligible for services under this Section;

(10) The consumer may not reside in a licensed residential setting. The individual's residence, while using Consumer Directed Home Based Care Services, may be the individual's home or a transitional living program. Personal Assistance Services cannot be delivered in an Adult Family Care Home (AFCH) setting or other licensed Assisted Living Facility which is currently reimbursed by state and/or federal funds for providing Personal Assistant Services; and

(11) If the assessment for continued eligibility indicates medical eligibility for a MaineCare program and potential financial eligibility for MaineCare, consumers will be given written notice that the consumer has up to thirty (30) days to file a MaineCare application. If Personal Assistance Services are currently being received, services shall be discontinued if an Office of Integrated Access and Support notice is not received within thirty (30) days of the assessment date indicating that a financial application has been filed. Services shall also be discontinued if, after filing the application within thirty (30) days, the application requirements have not been completed in the time required by MaineCare policy.

(12) If individuals are deemed not eligible for the program, efforts will be made to provide information and referral services to assist consumers in reaching appropriate service alternatives.

(B) Medical and Functional Eligibility Requirements

(1) A person meets the medical eligibility requirements for Consumer Directed Home Based Care if he or she requires limited assistance plus a one person physical assist with at least two (2) ADLs from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing.

(a) Activities of Daily Living:

(a) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

(b) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

(c) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
(d) Eating: How person eats and drinks;
(e) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
(f) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower; and
(g) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

(2) Must have the cognitive capacity, measured on the MED form, as defined in Section 11.01, to be able to direct the services. The Authorized Agent as part of the assessment will determine this capability;

(3) The individual must agree to complete initial consumer instruction and testing within thirty (30) days of date of the completion of the MED form to determine medical eligibility in order to develop and verify that they have attained the skills needed to hire, train, schedule and supervise assistants, and document the provision of personal assistance services identified in the Authorized Plan of Service. Consumers who do not complete the course of instruction or do not demonstrate to the Authorized Agency they have attained the skills needed to hire or select, fire, and train assistants, schedule, supervise and document the delivery of their identified care services, are not eligible under this section.

11.03 DURATION OF SERVICES

Each Consumer Directed Home Based Care consumer may receive as many covered services as identified, documented and authorized on the MED form, as required, within the limitations and exceptions described below. Home Based Care coverage of services under this Section requires prior authorization from the Department or its Authorized Agent. Beginning and end dates of an individual's medical eligibility determination period correspond to the beginning and end dates for Home Based Care coverage of the plan of service authorized by the Authorized Agent or the Department. The services provided must be reflected in the Service Plan and based upon the authorized covered services documented in the care plan summary of the MED form. The Maximum Authorized Service amount is 40 hours of services per week.

(A) The total monthly cost of services may not exceed the lesser of the monthly plan of service authorized by the Authorized Agent or the monthly cap, established by the Department.

(B) Suspension. Services will be suspended if the consumer is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days the consumer must be reassessed to determine appropriate services. Upon discharge from a hospital or institutional care facility, the consumer's previous level of service will resume until a reassessment is conducted. The reassessment will be conducted within two weeks following the consumer's discharge from the hospital or institutional care facility.

(C) Services under this Section may be suspended, reduced, denied or terminated by the Department or the Authorized Agent, as appropriate depending on the nature and severity of the situation, for the following reasons:

(1) The consumer does not meet eligibility requirements;
(2) The consumer declines services;
(3) The consumer is eligible to receive services under a MaineCare program, including any MaineCare Home or Community Based waiver program or a State funded long term care services program;
(4) Based on the consumer's most recent MED assessment, the plan of service is reduced to match the consumer's needs as identified in the reassessment and subject to the limitations of the program cap;
(5) The health or safety of the consumer or of individuals providing services is endangered;
(6) Consumer refuses personal assistance services;
(7) Consumer has failed to make his/her calculated monthly co-payment within thirty (30) days of receipt of the co-pay bill;
(8) When the consumer gives fraudulent information, including, but not limited to assessment information and reporting, payroll records, and all other record keeping documents to the Department of Health and Human Services or the Authorized Agent;
(9) The consumer fails to personally manage an assistant;
(10) The consumer is using program funds to pay the Personal Assistant to complete tasks outside the covered services described in Section 11.04;
(11) Failure of a consumer to demonstrate the skills necessary to successfully manage his/her personal health maintenance, including management of the PA in compliance with these rules;
(14) The consumer endorses or attempts to endorse a check that is made payable to the PA;
(15) The consumer fails to carryout his/her responsibilities for FICA withholding.

unemployment insurance or worker's compensation insurance;

(16) In the event that a consumer is found to have used program funds in violation of the requirements of this section, the consumer must reimburse the Authorized Agent for all such funds before being subsequently considered for services under this Chapter.

(17) In the event that services have been denied or terminated by the Authorized Agent or the Department for any of the reasons included in this section, such actions will be a factor in determining eligibility in any subsequent application for services under this rule.

Notice of intent to reduce, deny, or terminate services under this section will be done in accordance with Section 11.13 of this rule.

11.04 COVERED SERVICES

Covered services are available for individuals meeting the eligibility requirements set forth in Section 11.02. All covered services require prior authorization by the Department, or its Authorized Agent, consistent with these rules, and are subject to the limits in Section 11.03. The Authorized Plan of Service shall be based upon the consumer's assessment outcome scores recorded on the Department's Medical Eligibility Determination (MED) form, and its definitions.

Services provided must be required for meeting the identified needs of the individual, based upon the outcome scores on the MED form, and as authorized in the plan of service. Coverage will be denied if the services provided are not consistent with the consumer's authorized plan of service. The Department may also recoup payment from the Authorized Agent, pursuant to 22 MRSA § 1714-A, if applicable, for inappropriate service provision or overpayment, as determined through post payment review.

Covered Services are:

(A) Administration Costs of the overall administration of this program are built into the hourly rate for Personal Assistance Services. The Authorized Agent is responsible for overall administration including consumer assessment, monitoring, assistance, instruction, and assistant payment processing. Registered Nurses, Occupational Therapists and Certified Occupational Therapy Assistants are staff qualified to carry out these functions. Such tasks include:

(1) initiating eligibility assessments and re-assessments to determine medical eligibility and the consumer's ability to self-direct;

(2) determining the need for additional non-scheduled reassessments or additional skills training;

(3) providing skills training and testing;

~~(4) monitoring, through face-to-face contact, unless the consumer has previous experience with another personal assistance program, at least twice in the first six (6) months and annually thereafter to coincide with reassessment, documenting and taking appropriate action concerning any changes in the general health and welfare of the consumer;~~

(5) providing consumer instruction services as needed by the individual consumer to demonstrate competency in the direction and management of the PA for initially instructing the consumer in the management of Personal Assistants and additional instruction as needed.

(a) Consumer instruction services must be provided to each new eligible consumer prior to the start of services. The Authorized Agent must document that the consumer has successfully completed the training within thirty (30) calendar days of the date of determination of medical eligibility.

(b) Instruction in PA management includes: instruction in recruiting, interviewing, selecting, training, scheduling and directing a competent assistant in the activities identified in the authorized plan of service and if necessary terminating the PA's employment.

(c) Consumer instruction also includes instructing the consumer in his or her rights and responsibilities, including the obligations under the Consumer Directed Home Based Care policy.

(6) assessing the consumer/assistant relationship, including whether assistant duties are being performed satisfactorily, whether assistant training is adequate or if additional training is needed;

(7) issuing a notice of intent to reduce, deny or terminate services as defined in Section 11.03.

(B) Consumer Directed Personal Assistance Services

Consumers who qualify for Assistance Services are eligible for the following services:

(1) Bed mobility, transfer, and locomotion activities to get in and out of bed, wheelchair or motor vehicle;
(2) Using the toilet and maintaining continence;
(3) Health maintenance activities as defined in 11.01 (R)
(4) Bathing, including transfer;
(5) Personal hygiene which may include combing hair, brushing teeth, shaving, applying makeup, washing and drying face, hands, and perineum;
(6) Dressing;
(7) Eating, and cleanup;
(8) Household tasks for the consumer only, when authorized and specified in the Authorized Plan of Service. These tasks must be furnished in conjunction with direct service to the consumer and directed by the consumer;

(a) grocery and prepared food shopping, assistance with obtaining medication, to meet the consumer's health and nutritional needs;

(b) routine housework, including sweeping, washing and/or vacuuming of floors, cleaning of plumbing fixtures (toilet, tub, sink), appliance care, changing of linens, refuse removal;
(c) laundry done within the residence or outside of the home at a laundry facility;
(d) money management, as directed by the consumer, for the consumer, and
(e) meal preparation and clean up.

(C) Transportation. Transportation services may be provided only when a consumer is unable to be transported alone. Consumers shall first attempt to locate other resources before utilizing transportation services under this program. Travel time of the assistant shall be assessed only in the course of delivering a covered service and in support of IADLs as determined during the assessment. Additional time for transportation may not be added to the plan of service. A consumer may, however, substitute their existing hours of other activities necessary for independent living for transportation time. Any individual providing transportation must hold a valid State of Maine driver's license for the type of vehicle being operated. All providers of transportation services shall maintain adequate liability insurance coverage for the type of vehicle being operated

(D) Personal Emergency Response System (PERS). A Personal Emergency Response System is an electronic device which enables individuals to secure help in the event of an emergency. PERS services may be authorized for individuals who live alone, or who are alone for significant parts of the day, who are capable of using the system, and have no regular assistant for extended periods of time, and who would otherwise require extensive routine supervision. The use of the PERS will result in a reduction of authorized hours that are equal to the cost of the service.

11.05 NON COVERED SERVICES

The following services are not reimbursable under this Section:

(A) Rent and food;
(B) Services for which the cost exceeds the limits described in Section 11.03;
(C) Personal assistance services (defined in 11.01(BB) delivered in an Adult Family Care Home setting or other licensed Assisted Living Facility which is reimbursed for providing personal assistance services;

(D) Services provided by a Personal Assistant who is found to have convictions or complaints set forth under criminal background check requirements of Section 11.01(M);

(E) Homemaker and handyman/chore services not directly related to medical need;

(F) Those services which can be reasonably obtained by the consumer by going outside his/her place of residence;

(G) Travel time and mileage by the Authorized Agent, Authorized Agent's staff, and/or the assistant to and from the consumer's residence;

(H) Mileage for Personal Assistants;

(I) Household tasks except when delivered as an integral part of the Authorized Plan of Service as described in Section 11.04;

(J) Custodial, supervisory or respite care;

(K) Off-site services, except in the provision of covered IADLs;

(L) On call services;

(M) Any reimbursement for hours of services in excess of the Maximum Authorized Service amount.

11.06 POLICIES AND PROCEDURES

(A) Eligibility Determination

An eligibility assessment, using the Department's approved Medical Eligibility Determination (MED) form, shall be conducted by the Department or the ASA. All Home Based Care services require an eligibility determination and prior authorization by the Authorized Agent to determine eligibility pursuant to Section 11.02.

(1) The ASA will accept verbal or written referral information on each prospective new consumer, to determine appropriateness for an assessment. When funds are available to conduct assessments, prospective consumers will receive a face to face medical eligibility determination assessment at their current residence within fifteen (15) business days of the date of referral to the Authorized Agent. All requests for assessments shall be documented indicating the date and time the assessment was requested and all required information provided to complete the request. The individual conducting the assessment shall be a Registered Nurse (RN), occupational therapist (OT) or a certified occupational therapy assistant (COTA), whose work will be reviewed and signed off by an OT, and will be trained in conducting assessments and developing an authorized plan of service with the Department's approved MED tool. The assessor's findings and scores recorded in the MED form shall be the basis in establishing eligibility for services and the authorized plan of service. The anticipated costs of covered services to be provided

under the authorized plan of service must conform to the limits set forth in Section 11.03(A).

(2) The ASA shall inform the consumer of available community resources and authorize a plan of service that reflects the identified needs documented by scores and timeframes on the MED form, giving consideration to the consumer's living arrangement, informal supports, and services provided by other public and private funding sources. CDHBC services provided to two or more consumers sharing living arrangements shall be authorized by the Authorized Agent with consideration to the economies of scale provided by the group living situation, according to limits in Section 11.03. The Authorized Agent shall authorize a plan of service based upon the scores and findings recorded in the MED assessment. The covered services to be provided in accordance with the authorized plan of service shall: 1) not exceed the lesser of the monthly plan of service authorized by the Authorized Agent or the Maximum Authorized Service established by Department of Health and Human Services; and 2) be prior authorized by the Department or its Authorized Agent. The assessor shall approve an eligibility period for the consumer, based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment.

(3) The assessor will provide a copy of the authorized service plan, in a format understandable by the average reader and approved by the Department, a copy of the eligibility notice, release of information and the appeal hearing rights notice, to the consumer at the completion of the assessment. The assessor will inform the consumer of the estimated co-payment and the cost of services authorized.

(4) The assessor shall forward the fully completed assessment packet to the Department within five (5) business days of the medical eligibility determination and authorization of the plan of service. The Department will not approve eligibility or payment without a fully completed assessment.

(5) The Authorized Agent will complete initial skills training within thirty (30) days of the date of the completion of the medical eligibility determination form. Payment of Consumer Directed services can begin only after the Department is notified that the consumer has successfully completed this training and the complete medical eligibility packet has been received.

(B) Waiting List

(1) Consumers will be assessed on a first come, first served basis.

(2) For consumers found ineligible for CDHBC services the Authorized Agent will inform each consumer of alternative

services or resources, and offer to refer the person to those other services.

(3) When funds are not available to serve new consumers, or to increase needed services to current consumers, a waiting list will be established by the Department in consultation with the Authorized Agent. Individuals on the waiting list will be interviewed by the Authorized Agent by phone for a pre-admission screening to determine their potential eligibility. As funds become available consumers will be taken off the list, fully assessed, and served on a first come, first served basis.

(4) When there is a waiting list, the Authorized Agent will inform each consumer who is placed on the waiting list of alternative services or resources, and offer to refer the person to those other services.

(5) The Authorized Agent will maintain one statewide waiting list.

(6) The Authorized Agent must suspend services if the consumer is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days, the consumer participation in the program will be suspended, and the consumer will be reassessed to determine medical eligibility for these services. Consumers will continue to receive their prior level of service until a reassessment is completed. The reassessment will be conducted within two weeks following the consumer's discharge from the hospital or institutional care facility.

(C) Reassessment and Continued Services

(1) For all consumers under this section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and prior authorization of services is required and must be conducted within the timeframe of 15 days prior to and no later than the reassessment due date. CDHBC payment ends with the reassessment date, also known as the end date.

(2) The Authorized Agent shall review, face-to-face, with the consumer, at the consumer's residence, the medical eligibility for services at least twice during the first six months the consumer received services under this section and at least annually thereafter, or when there is a significant change as defined in 11.01(FF). The agent shall provide consumer instruction services as needed by the individual consumer to demonstrate competency in the direction and management of the PA for initially instructing the consumer in the management of Personal Assistants and additional instruction as needed.

(3) Significant change reassessments will be requested by the consumer. According to the definition in Section 11.01(DD) the Authorized Agent will review the request and the most recent

assessment to determine whether a reassessment is warranted and has the potential to change the level of service or alter the authorized plan of service.

(4) For consumers currently under the appeal process, reassessments will not be conducted unless the consumer experiences a significant change as defined in Section 11.01(GG) or no longer has the ability to self direct as defined in Section 11.01 (EE).

11.07 PROFESSIONAL AND OTHER QUALIFIED STAFF

(A) Registered Professional Nurse

A registered professional nurse employed directly or through a contractual relationship or acting as an individual practitioner may provide services by virtue of possession of a current license to practice their health care discipline in the State in which the services are performed.

(B) Occupational Therapist

An occupational therapist must be licensed to practice occupational therapy by the Maine Board of Occupational Therapy Practice, as documented by written evidence from such Board.

(C) Certified Occupational Therapy Assistant (COTA) An Occupational Therapy Assistant who is licensed to practice occupational therapy in the State of Maine, under the documented (co-signed) supervision of a licensed occupational therapist.

(D) Personal Assistants

Assistants must be at least 16 years old and have the ability to assist with activities of daily living as defined in Section 11.02. Consumers are responsible for complying with all state and federal child labor laws relating to Assistants under 18 years old. The Department will not reimburse for the services of an assistant individual who has a record of a conviction or complaint as set forth in Section 11.05(D) of these rules.

After the completion of the consumer's skills training, the consumer trains the assistant on the job. Within a twenty-one (21) day probation period, the consumer will determine the competency of the assistant on the job. At a minimum, based upon the Personal Assistant's job performance, the consumer will certify competence in the following areas:

(a) ability to follow oral, or signed, and written instructions and carry out tasks as directed by the consumer;
(b) disability awareness;
(c) use of adaptive and mobility equipment; transfers and mobility; and

(e) ability to assist with activities of daily living and health maintenance activities.

Satisfactory performance will result in the consumer completing a PA competency form. This statement is signed by the consumer, submitted to the AA, and a copy is kept in the consumer's record.

11.08 PROGRAM RESPONSIBILITIES

(A) Consumer Control and Responsibility

(1) Employment of Personal Assistant. The consumer must control and direct the PA in the selection, hiring, management, training, scheduling, and, when necessary, termination of his or her PA. The consumer shall accept personal responsibility for all of the requirements listed below relating to his or her PA, including:

(a) Hiring, training, supervision, and termination of the PA;
(b) Establishing work schedules;
(c) Carrying out the plan of service as it relates to the PA and using the PA responsibly;
(d) Unemployment and workers compensation insurance, unless the consumer has chosen to have this carried out by the AA ; and
(e) Maintaining records, which comply with Maine State employment laws.

(2) Payroll reports. Consumers shall submit payroll documentation and reports, including W-2 and W-4 forms, as required by the established payroll providers and schedules as determined by the Department, the Authorized Agent, and the Internal Revenue Service.

(3) PA Documentation. The consumer must file with the Authorized Agent at least two copies of documents used during the hiring process to determine identification and employment status. Such documents will be those that meet the requirements of the Employment Eligibility Verification Form of the U.S. Department of Justice, commonly known as the I-9 Form.

(4) Department Requests. Consumers shall provide all information requested by the Department, including surveys of the program for evaluation and planning purposes.

(5) Compliance with Applicable Laws. Consumers shall comply with all federal and state laws relating to child labor and employment relationships, including but not limited to, matters relating to hiring, benefits, conditions of work, and terminations.

(6) Notice of Change. Consumers shall notify the Authorized Agent as soon as possible about any of the following matters:

(a) Changes in name, address, telephone number, Personal Assistant, amount of PA services needed, guardianship, agent, or designee, if any;

(b) Plans to leave the state or actual absences from the State in excess of 183 days during the year;

(c) Hospitalization;

(d) Any institutional stays where assistant services are available to the consumer;

(e) Changes in MaineCare eligibility;

(f) Changes in the type or amount of assistance services received through another source or program;

(g) Changes in need for assistant services including changes in disability, medical condition, or living situation which substantially affect the need for assistant services; and

(h) Any other changes in their eligibility as referenced in Section 11.02 Eligibility for Services or Section 11.03 Duration of Services.

(7) Personal Assistants Under the Age of Eighteen (18). All Personal Assistants under the age of eighteen (18) must report their age and social security number to the Authorized Agent. Personal Assistants must be at least 16 years of age.

(B) Responsibilities of the Department of Health and Human Services

(1) Selection of Authorized Agent. To select authorized agencies, the Department of Health and Human Services will request proposals at least every three (3) years by publishing a notice in Maine's major daily newspapers and posting on the Department of Health and Human Services website. The notice will summarize the detailed information available in a request for proposals (RFP) packet and will include the name, address, and telephone number of the person from whom a packet and additional information may be obtained. The packet will describe the specifications for the work to be done. Criteria used in selection of the successful bidder or bidders will include but are not necessarily limited to:

(a) Cost;

(b) Organizational capability;

(c) Response to a sample case study;

(d) Qualifications of staff;

(e) References;

(f) Quality assurance plan;

(g) Ability to comply with applicable program policies;

(i) Demonstrated experience; and

(ii) Understanding of disability and independence issues of consumers.

~~(2) Other Responsibilities of the Department of Health and Human Services. The Department of Health and Human Services is responsible for:~~

~~(a) Setting the Maximum Authorized Service amount.~~

~~(b) Establishing performance standards for contracts with authorized agencies including but not limited to the numbers of consumers to be assessed and served and allowable costs for administration and direct service.~~

~~(c) Conducting or arranging for quality assurance reviews that will include record reviews and home visits with CDHBC consumers.~~

~~(d) Establishing and maintaining a quality assurance review committee (QARC).~~

~~(i) The QARC is responsible for:~~

~~(a) Making recommendations for policy changes to the Department of Health and Human Services;~~

~~(b) Make recommendations for improving quality of care and outcomes for the consumer. The QARC may review the Department's Quality Assurance data and reports;~~

~~(c) Meeting as often as necessary, but at least four times annually;~~

~~(d) Using procedures that ensure consumer confidentiality.~~

~~(ii) The QARC shall have at least six (6) members. The Department of Health and Human Services is responsible for scheduling, notifying and recruiting new members, and documenting and distributing the meeting minutes and case review summaries to all members. Membership on the QARC must include:~~

~~1. Program Consumers sufficient in numbers to be a majority of the QARC's members;~~

~~2. The Assessing Services agency staff;~~

~~3. Service Authorized Agents;~~

~~4. A Program Director from the Department of Health and Human Services, or their designee, and~~

~~5. Staff from the Long Term Care Ombudsman.~~

~~(e) Providing training and technical assistance.~~

(f) Providing written notification to the authorized agencies regarding strengths, problems, violations, deficiencies or disallowed costs in the program and requiring action plans for corrections.

(g) Assuring the continuation of services if the Department of Health and Human Services determines that an authorized agent's contract must be terminated.

(h) Administering the program directly in the absence of a suitable authorized agent.

(i) Conducting a request for proposals for authorized agents at least every three years thereafter.

(j) At least annually, review the randomly selected requests for waivers of consumer payment.

(k) Recouping CDHBC funds from authorized agencies when the Department of Health and Human Services determines that funds have been used in a manner inconsistent with these rules or the authorized agent's contract.

(l) Review of reimbursement rates. The Director shall review the rates of reimbursement under the program subject to the provisions of 34-B M.R.S.A. §5438.

(C) Authorized Agent Responsibilities

(1) The Authorized Agent shall:

(a) Employ staff qualified by training and/or experience to perform assigned tasks and meet the applicable licensure requirements.

(b) Comply with requirements of 22 M.R.S.A. §3471 et seq. and 22 M.R.S.A. §4011-A – 4017 to report any suspicion of abuse or neglect.

(c) Pursue other sources of reimbursement for services prior to the authorization of CDHBC services.

(d) Operate and manage the program in accordance with all requirements established by rule or contract.

(e) Have sufficient financial resources, other than Federal or State funds, available to cover any CDHBC expenditures that are disallowed as part of the Department of Health and Human Services utilization review process.

(f) Inform in writing any consumer with an unresolved complaint regarding their services about how to contact the Long Term Care Ombudsman and the Department.

(g) Assure that costs to CDHBC funds for services provided to a consumer in a twelve month period do not exceed the applicable annual service plan cost limit, for which the consumer is determined eligible, established by the Department of Health and Human Services.

(h) Implement an internal system to assure the quality and appropriateness of assessments to determine eligibility and authorize service plans including, but not limited to the following:

1. Consumer satisfaction surveys;
2. Documentation of all complaints, by any party including any resolution action taken;
3. Measures taken by the Authorized Agent to improve services.

(i) Participate in the Quality Assurance Review Committee as required by the Department of Health and Human Services.

(j) Assure that consumers receive training on the following:

(i) maintaining records which comply with Maine State employment laws;

(ii) child labor laws and the appropriate forms to use if employing a PA who is under eighteen (18) years of age;

(iii) conducting a background check on possible PAs;

(iv) HIPPA confidentiality requirements; and

(v) information on advertising, hiring, job descriptions, supervision, management, and scheduling assistants.

Travel time to and from the location of the consumer is excluded.

(k) Assure contact with each consumer at least twice in the first six months and at least annually, or more often as deemed appropriate by staff, to verify receipt of authorized services, discuss consumer's status, review any unmet needs and provide appropriate follow-up and referral to community resources.

(l) Assure each Consumer's compliance with worker's compensation coverage, unemployment insurance coverage and FICA withholding for employees reimbursed with program funds.

(m) Make efforts to make any existing worker's compensation pools available to program consumers.

(2) Consumer Records and Program Reports.

(a) Content of Consumer Records. The Authorized Agent must establish and maintain a record for each consumer that includes at least:

(i) The consumer's name, address, mailing address if different, telephone number, and if available, an email address;

(ii) The name, address, and telephone number of someone to contact in an emergency;

(iii) Complete medical eligibility determination form and financial assessments and reassessments that include the date they were done and the signature of the person who did them;

(iv) A service plan summary that promotes the consumer's independence, matches needs identified by the scores on the MED form, and is authorized by the Authorized Agent in the service plan summary on the MED form, with consideration of other formal and informal services provided and which is reviewed annually. The service plan includes:

(a) Evidence of the consumer's participation;

(b) Identification of needs;

(c) The desired outcome;

(d) Who will provide what service, when and how often, reimbursed by what funding source, the reason for the service and when it will begin and end;

(e) The signature of the assessor who determined eligibility and authorized a plan of service; and

(v) A dated release of information signed by the consumer that conforms with applicable law, is renewed annually and that:

(a) Is in language the consumer can understand;

(b) Names the agency or person authorized to disclose information;

(c) Describes the information that may be disclosed;

(d) Names the person or agency to whom information may be disclosed;

(e) Describes the purpose for which information may be disclosed; and

(f) Shows the date the release will expire.

(vi) Documentation that consumers eligible to apply for a waiver for consumer payments, were notified that a waiver may be available;

(vii) Evidence that the consumer has certified competency of the PA;

(viii) Written progress notes that summarize any contacts made with or about the consumer and:

(a) The date and duration of the contact;

(b) The name and affiliation of the person(s) contacted or discussed;

(c) Any changes needed and the reasons for the changes in the plan of service;
(d) The results of any findings of MDT contacts or meetings and, if applicable, of quality assurance review committee (QARC) meetings; and
(e) The signature and title of the person making the note and the date the entry was made;
(ix) Proof of required FICA, Unemployment and Workers Compensation contibution and coverage; and
(xi) Documentation of all complaints, by any party, including resolution action taken.

(b) Program Reports. The following reports must be submitted to the Department of Health and Human Services, in a format approved by the Department of Health and Human Services, by the day noted:
(1) Monthly service and consumer reports including admissions, discharges and active consumer lists, due no later than twenty days after the end of the month;
(2) Monthly fiscal reports, due no later than twenty days after the end of the month;
(3) Quarterly and annual demographic reports, due no later than twenty five days after the end of the quarter; and
(4) Monthly authorizations for CDHBC services, due by the tenth of the month for which authorizations are reported.
(5) Monthly reports of the type and number of assessments completed by the authorized agent as required by the contract with the Department of Health and Human Services.

~~11.09 CONSUMER PAYMENTS (MAJOR SUBSTANTIVE RULE)~~

~~**(A) Consumer Payments.** The authorized agency will use a Department of Health and Human Services approved form to determine income and liquid assets and calculate the monthly payment to be made by the consumer. The agency may require the consumer and his or her spouse to produce documentation of income and liquid assets. A consumer need not complete a financial assessment if he or she pays the full cost of services received. His or her payments, as determined by an annual financial assessment may not exceed the total cost of services provided.~~

(B) Definitions. The following definitions apply to this Section.

(1) Dependent Allowances. Dependents and dependent allowances are defined and determined in agreement with the method used in the MaineCare program. The allowances are changed periodically and cited in the MaineCare Eligibility Manual, Chart II, AFDC Related Income Limits. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.

(2) Disability-related expenses: Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:

(a) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening, environmental controls;

(b) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response Systems;

(c) Wheelchair (manual or power) accessories: lab tray, seats and back supports;

(d) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;

(e) Hearing Aids, glasses, adapted visual aids;

(f) Assistive animals (purchase only);

(g) Physician ordered medical services and supplies;

(h) Physician-ordered prescription and over the counter drugs; and

(i) Medical insurance premiums, co-pays and deductibles.; and

(j) Unemployment and workers compensation expenses related to employing the PA.

(3) Household members: means the consumer and the spouse.

(4) Household members income includes:

(a) Wages from work, excluding state and Federal taxes and employer mandated or court ordered withholdings of the consumer and the spouse;

(b) Benefits from Social Security, Supplemental Security Income, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;

(c) Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax;

(d) Interest and dividends.

(e) Regularly occurring payments received from a home equity conversion mortgage.

Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.

(5) A liquid asset is something of value available to the consumer that can be converted to cash in three months or less and includes:

(a) Bank accounts;

(b) Certificates of deposit

(c) Money market and mutual funds;

(d) Life insurance policies;

(e) Stocks and bonds;

(f) Lump sum payments and inheritances; and

(g) Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form.

Funds which are available to the consumer but which carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.

(C) Consumer Payment Formula. The Authorized Agent will use the following formula to determine the amount of each consumer's payment.

Step (1) Calculate the Monthly Contribution from the Household Income

(a) Total the monthly income of household members.

(b) Deduct monthly allowable disability related expenses.

(c) Deduct monthly allowable dependent allowances.

(d) Multiply the net income by 4%.

Step (2) Calculate the Monthly Contribution from Liquid Assets.

~~(a) Total the liquid assets of household members.~~

~~(b) Deduct annual interest and annual dividends counted toward income for the household.~~

~~(c) Subtract $30,000 from the amount of liquid assets calculated in Step (2)(a&b).~~

~~(d) Multiply the sum calculated in Step (2)(c) by 3%. The result is the Monthly Contribution from Liquid Assets. If the result is less than zero use zero.~~

~~**Step (3)** - Add the result of the calculation in Step (1)(d), to the result of the calculation in Step (2)(d).~~

~~**Step (4)** - The consumer's monthly payment is the lesser of the sum calculated in Step (3) or the actual cost of services provided during the month.~~

~~**Step (5)** - When two persons in a household are both receiving home based care services under this program, collect the required information for each person. Calculate the co-pay for each consumer and combine the total. Divide the amount by two to determine the household monthly co-payment.~~

~~**(D) Waiver of Consumer Payment.** Consumers will be informed that they may apply for a waiver of all or part of the assessed payment when:~~

~~**(1)** Monthly income of household members is no more than 200% of the federal poverty level; and~~

~~**(2)** Assets are less than $30,000 for the household.~~

~~11.10 METHOD FOR REVIEWING REQUESTS FOR WAIVERS OF CONSUMER PAYMENT (MAJOR SUBSTANTIVE RULE)~~

~~**(A)** Consumers requesting waivers may be asked to provide verification of any income, liquid assets and expenses for housing, transportation, unreimbursed medical expenses, food, clothing, laundry and insurance.~~

~~**(B)** Consumers may request a waiver from the authorized agency of all or part of the assessed payment.~~

~~**(1)** The request must be submitted in writing:~~

~~**(a)** within ten (10) days of the date of notification of the assessed consumer payment, or~~

~~**(b)** within ten (10) days of the date of their last functional reassessment.~~

~~**(2)** Requests for waiver must be on a form approved by the Department of Health and Human Services.~~

(3) The authorized agency will act on the request and inform the consumer of its decision in writing within twenty (20) days of receipt of the request.

(4) If the authorized agency needs additional information, in order to determine whether the waiver can be granted, the authorized agency will promptly notify the consumer. The consumer must submit the additional information within ten (10) days. In such cases the agency will issue its decision within ten (10) days of receipt of the additional information.

(C) A consumer who is otherwise eligible may receive services while awaiting the agency's decision on the request for waiver. The agency will hold the consumer payment in abeyance pending a decision on the request, or the completion of the appeals process, whichever is later.

(D) The agency will inform the consumer in writing if the request for a waiver is approved or denied. If denied, the agency's notice must include information on appeal rights.

(E) If the waiver is denied, the consumer payment, including payments held in abeyance, is due within thirty (30) days of the date of the decision, or services will be terminated.

(F) When allowable expenses plus the consumer payment exceed the sum of monthly income plus the Monthly Contribution From Liquid Assets, the agency will waive the portion of the payment that causes expenses to exceed income.

(G) Consumers who have applied for a full or partial waiver of the assessed payment and been denied may reapply only if one of the following conditions exists and is expected to continue until the next regularly scheduled financial assessment:

(1) the consumer has at least a 20% decrease in monthly income or liquid assets.

(2) has an increase in expenses which results in the sum of the allowable expenses plus the consumer payment exceeding monthly income plus the Monthly Contribution From Liquid Assets.

(H) **Expenses.** Expenses will be reduced by the value of any benefit received from any source that pays some or all of the expense. Examples include but are not limited to, Medicare, MaineCare, Food Stamps, Elderly Low Cost Drug and Property Tax and Rent Refund. Business expenses that exceed business income are not allowable. Allowable expenses include actual monthly costs of all household members for:

(1) housing expenses which include and are limited to rent, mortgage payments, property taxes, home insurance, heating, water and sewer, snow and trash removal, lawn mowing, utilities and necessary repairs;

~~**(2)** food, clothing and laundry not to exceed;~~

~~**Number in Household**~~	~~**1**~~	~~**2**~~	~~**3**~~	~~**4**~~	~~**5 & up**~~
~~**Amount**~~	~~$208~~	~~$325~~	~~$435~~	~~$544~~	~~$654~~

~~**(3)** transportation expenses which include and are limited to ferry or boat fees, car payments, car insurance, gas, repairs, bus, car and taxi fare;~~

~~**(4)** unreimbursed medical expenses including but not necessarily limited to health insurance; prescription or physician ordered drugs equipment and supplies; and doctor, dentist and hospital bills;~~

~~**(5)** life insurance;~~

~~**(6)** child care expenses;~~

~~**(7)** limited discretionary expenses.~~

~~The following chart shows maximum allowable discretionary expenses by household size. Amounts in excess of the monthly allowance may not be claimed.~~

~~**Number in Household**~~	~~**1**~~	~~**2**~~	~~**3**~~	~~**4**~~	~~**5 & up**~~
~~**Amount**~~	~~$55~~	~~$79~~	~~$103~~	~~$133~~	~~$157~~

~~11.11 APPEALS PROCESS~~

~~(A) The Department or its Authorized Agent must notify the consumer in writing that he/she has the right to appeal any decision to reduce, deny, or terminate services provided under this Chapter. In order for services to continue during the appeal process, the Department must receive a request for an appeal within ten (10) days of the notice to reduce, deny, or terminate services. Otherwise, the Department must receive a request for an appeal within sixty (60) days of the date of the notice to reduce, deny, or terminate services. The Department or Authorized Agent shall inform consumers in writing of their right to request an administrative hearing in accordance with this section.~~

~~(B) Requests for appeal must be made by the consumer or his or her representative in writing to the Department of Health and Human Services, CDPAS Program, 2nd floor Marquardt Building, Augusta ME 04333, or by telephone by calling 287-4242 or TTY 1-800-606-0215 . The date a written or verbal request is received by the Department is considered the date of request for the hearing.~~

~~(C) If any of the following circumstances exist, the Office of Administrative Hearings, Maine Department of Health and Human Services may dismiss the request for an administrative hearing. This dismissal is the final agency action on this matter.~~

~~1. The Consumer withdraws the request for the hearing.~~
~~2. The Consumer, without good cause, abandons the hearing by failing to appear.~~
~~3. The sole issue being appealed is one of federal or state law or policy requiring and automatic change adversely affecting some or all consumers.~~
~~4. The consumer dies.~~

~~Where an consumer's request for an administrative hearing is dismissed pursuant to this Section, the Office of Administrative Hearings shall notify the member of his/her right to appeal that decision in Superior Court.~~

~~(D) The hearing will be held in conformity with the Maine Administrative Procedure Act at 5 M.R.S.A. §§ 9051-9064 and the Office of Administrative Hearing's Administrative Hearing Regulations.~~

TABLE OF CONTENTS

63.01 INTRODUCTION

Home Based Supports and Services (HBSS) for Older and Disabled Adults is a state funded program to provide long term care services to assist eligible Consumers to avoid or delay institutionalization. Provision of these services is based on the availability of funds. State funds furnished through 22 M.R.S. §§ 7301-06, 21-23 and 34-B M.R.S. § 5439 may not be used to supplant the resources available from families, neighbors, agencies and/or the Consumer from other federal or state programs unless specifically provided for elsewhere in this Section. State HBSS funds shall be used to purchase only those covered services that are essential to assist the Consumer to avoid or delay institutionalization and which will foster independence, consistent with the Consumer's circumstances and the Authorized Plan of Care. This program supports Consumer choice, Consumer direction, flexibility, as well as Consumer responsibility in the provision of these services.

All provisions of this rule are routine technical, except for the Consumer Payments provision (Section 63.12) which is a major substantive rule provision pursuant to 34-B M.R.S. § 5439(9).

63.02 DEFINITIONS

63.02-1 **Activities of Daily Living (ADLs)** are basic activities of self-care performed by individuals on a daily or frequent basis necessary for independent living and may include activities such as:

A. **Bed Mobility**: How a person moves to and from lying position, turns side to side, and positions body while in bed;

B. **Transfer**: How a person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

C. **Locomotion:** How a person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

D. **Eating**: How a person eats and drinks (regardless of skill);

E. **Toilet Use**: How a person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;

F. **Bathing**: How a person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and

G. **Dressing**: How a person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

63.02-2 **Acute/Emergency Episode** is the unforeseen occurrence of an acute health episode that requires a change in the Consumer's Authorized Plan of Care, or the unforeseen circumstance where the availability of the Consumer's caregiver or informal support system is compromised.

63.02-3 **Assessing Services Agency (ASA)** is an Authorized Agent providing services to the Department for medical eligibility determinations, and Authorized Plan of Care development under this Section. The ASA conducts face-to-face assessments, using the Department's Medical Eligibility Determination (MED) Form. A Consumer's medical eligibility is based upon a Consumer's assessment outcome. If medical eligibility is determined for this Section, the ASA develops the Authorized Plan of Care with the Consumer and specifies all services to be provided under this Section, including type of services and number of hours for all Provider types.

63.02-4 **Assisted Living Services** is the provision of assisted housing services with the addition of Medication Administration and nursing services by an assisted housing program, either directly by the Provider or indirectly through contracts with persons, entities or agencies.

63.02-5 **Attendant** is an individual who meets the qualifications required in Section 63.09-2(F). The Attendant provides Personal Care Services specified in the Authorized Plan of Care to a Consumer utilizing the consumer-directed option.

63.02-6 **Authorized Agent** is an organization authorized by the Department to perform functions under a valid contract or other approved, signed agreement. The Assessing Services Agency and any designated Service Coordination Agency are Authorized Entities under this Section.

63.02-7 **Authorized Plan of Care** is a plan authorized by the Assessing Services Agency, or the Department, and which specifies all services to be delivered to a Consumer under this Section, including the number of hours for each covered service, and the Provider type to deliver each service. The Authorized Plan of Care shall be based upon the Consumer's assessment outcome scores recorded in the Department's Medical Eligibility Determination Form, utilizing the time frames contained therein, and the professional clinical judgment of the assessor.

The Authorized Plan of Care shall reflect the needs identified by the assessment, taking into account the Consumer's goals, preferences, living arrangement, informal caregiving supports provided by family and friends, and services provided by other public and private funding sources.

63.02-8 **Back Up Plan** is a part of the service plan that addresses contingencies such as emergencies, including the failure of a worker to appear as scheduled, when the absence of the service presents a risk to the Consumer's health and welfare. The Back Up Plan also identifies potential risks to Consumers and the development of

strategies to mitigate such risks that are integral to enabling Consumers to live in the community while ensuring their health and welfare.

63.02-9 **Cognitive Capacity** is the mental function of knowing, including aspects of awareness, perception, reasoning, and judgment, assessed for purposes of determining a Consumer's ability to self-direct their care.

63.02-10 **Consumer** is an individual who meets the eligibility requirements of this Section and is authorized to receive services. A Consumer may be represented by their "guardian," "agent," or "surrogate," as these terms are defined in 18-A M.R.S. § 5-801, or by a Representative as defined in this Section.

63.02-11 **Cueing** is any spoken instruction or physical guidance which serves as a signal to do an activity and typically used when supporting Consumers who are cognitively impaired.

63.02-12 **Department** is the Maine Department of Health and Human Services.

63.02-13 **Dependent Allowances** are defined and determined in agreement with the method used in the MaineCare program. The allowances are changed periodically and cited in the MaineCare Benefits Manual and the TANF Standard of Need Chart, 10-144 C.M.R. ch. 331. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the Consumer or Consumer's spouse.

63.02-14 **Direct Care Provider** is a Provider who has a contract with a Service Coordination Agency that directly provides personal care, home health or in-home respite services under this Section**.**

63.02-15 **Disability-Related Expenses** are out-of-pocket costs incurred by the Consumer for their disability, which are not reimbursed by any third-party sources.

63.02-16 **Fiscal Intermediary** is a Provider of financial management services on behalf of Consumers utilizing Attendants through the consumer-directed option. The Fiscal Intermediary's responsibilities include, but are not limited to, preparing payroll and withholding taxes, making payments for Attendant services and ensuring compliance with state and federal tax and labor regulations, and the requirements under this Section.

The Fiscal Intermediary acts as an entity of the employer (i.e., the Consumer or the Consumer's Representative) in accordance with Federal Internal Revenue Service codes and procedures.

63.02-17 **Health and Welfare Tool** is an evaluation completed by the Service Coordination Agency to assess risks and unmet needs of Consumers as required by the Department.

63.02-18 **Health Maintenance Activities** are activities designed to assist the Consumer with Activities of Daily Living and Instrumental Activities of Daily Living, and additional activities specified in this definition. These activities are performed by a designated caregiver for a Consumer who would otherwise perform the activities if they were physically or cognitively able to do so and enable the Consumer to live in their home and community. These additional activities include, but are not limited to catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, and occupational and physical therapy activities such as assistance with prescribed exercise regimes.

63.02-19 **Income** is defined as:

A. Wages from work, including payroll deductions, excluding state and federal taxes and employer mandated or court ordered withholdings;

B. Benefits from Social Security, Supplemental Security Insurance, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;

C. Adjusted gross income from property and/or business, based on the Consumer's most recent federal income tax; and

D. Interest and dividends.

Income does not include: Low Income Home Energy Assistance Program (LIHEAP); Supplemental Nutrition Assistance Program (SNAP); General Assistance; and Maine Property Tax Fairness Credit pursuant to 36 M.R.S. § 5219-II.

63.02-20 **Instrumental Activities of Daily Living (IADLs)** are tasks necessary for maintaining a Consumer’s immediate environment, such as preparing and serving meals, washing dishes, dusting, making bed, pick-up living space, sweeping, vacuuming and washing floors, cleaning toilet, tub and sink, appliance care, changing linens, refuse removal, shopping for groceries and prepared foods, storage of purchased groceries, and laundry, either within the residence or at an outside laundry facility.

63.02-21 **Licensed Assisted Living Agency** is a state funded agency licensed with the Department as an assisted living program and holds a valid contract with the Department to provide services. These Providers employ Certified Residential

Medication Aides (CRMAs) with the intention to serve Consumers who have daily Medication Administration needs as outlined in Level V.

63.02-22 **Limited Assistance** is a term used to describe a Consumer's self-care performance in Activities of Daily Living, as defined by the Minimum Data Set (MDS) assessment process. Limited Assistance means the resident was highly involved in the activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance on three (3) or more times during the last seven (7) days.

63.02-23 **Liquid Asset** is something of value available to the Consumer that can be converted to cash in three (3) months or less and includes:

A. Bank accounts;

B. Certificates of deposit;

C. Money market and mutual funds;

D. Life insurance policies;

E. Stocks and bonds;

F. Lump sum payments and inheritances;

G. Funds from a home equity conversion mortgage that are in the Consumer's possession whether they are cash or have been converted to another form;

H. Funds which are available to the Consumer but carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide Income as a replacement for earned Income. The Income from these payments will be counted as Income; and

I. Revocable and irrevocable trusts.

63.02-24 **Medical Eligibility Determination (MED) Form** is the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms, and timeframes relating to this form, as defined in this Section, provide the basis for services and the care plan authorized by the Assessing Services Agency. The care plan summary, contained in the MED Form, documents the authorized care plan to be implemented by the Service

Coordination Agency in the service order or, for Level V, by the Licensed Assisted Living Agency. The care plan summary also identifies other services the recipient is receiving, in addition to the authorized services provided under this Section.

63.02-25 **Medication Administration** for Level V is the daily administration of routine prescription medications by a Licensed Assisted Living Agency performed by a Certified Residential Medication Aide (CRMA) under the supervision of a registered nurse.

63.02-26 **Multi-Disciplinary Team (MDT)** is the team involved in an individual's care and may include the following:

A. The Consumer;

B. Service Coordination Agency staff, as appropriate;

C. The registered nurse assessor, or a health professional; and

D. Other people who provide or have an interest in the Consumer's services.

63.02-27 **Nursing Services** consist of the following:

A. Intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of unstable conditions requiring medical or nursing intervention other than daily insulin injections for a Consumer whose diabetes is under control;

B. Nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past thirty (30) days) or unstable condition;

C. Nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within past thirty (30) days) or unstable condition;

D. Treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, second or third degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

E. Administration of oxygen on a regular and continuing basis when the recipient's medical condition warrants professional nursing observations, for a new or recent (within past thirty (30) days) condition;

F. Professional nursing assessment, observation and management of an Unstable Medical Condition (observation must, however, be needed at least once every eight hours throughout the twenty-four (24) hours);

G. Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the recipient's medical record;

H. Services to manage a comatose condition;

I. Care to manage conditions requiring a ventilator/respirator;

J. Direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grandmal);

K. Physician-ordered occupational, physical, or speech/ language therapy or some combination of the three (time limited with patient-specific goals) which is provided by and requires the professional skills of a licensed or registered therapist. Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist. Maintenance or preventive services do not meet the requirements of this section;

L. Professional nursing assessment, observation and management of a medical condition;

M. Administration of treatments, (excluding nebulizers, CPAP or BIPAP systems and airway clearance system vest), procedures, or dressing changes which involve prescription medications for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring;

N. Professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis;

O. Professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability; and

P. Professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior.

63.02-28 **Office of Aging and Disability Services (OADS):** means the designated office within the Maine Department of Health and Human Services that supports the needs of older and disabled adults.

63.02-29 **One-Person Physical Assist** requires one person over the last seven (7) days or twenty-four (24) to forty-eight (48) hours if in a hospital setting, to provide either weight-bearing or non-weight bearing assistance for a Consumer who cannot perform the activity independently. This does not include Cueing.

63.02-30 **Person-Centered Planning** is a process used to ensure that the Consumer's assessment, service plan development, and services and supports are led by the Consumer. This process encourages the Consumer to maintain their independence; retain connections to their community, family, and friends; and to receive support in a manner that respects their goals, values and preferences.

63.02-31 **Personal Care Agency** is a non-medical entity that provides Personal Care Services to individuals in their homes. Personal Care Agencies are subject to the licensing and regulatory authority of the Department and must adhere to applicable statutes and rules, including 22 M.R.S. § 1717.

63.02-32 **Personal Care Services** are those covered ADL and IADL services provided by a home health aide, certified nursing assistant, Personal Support Specialist, or Attendant which are required by an adult with long-term care needs to achieve greater physical independence, in accordance with the Authorized Plan of Care.

63.02-33 **Personal Support Specialist (PSS)** is a person who provides Personal Care Services for ADL and IADL needs and has completed a Department approved training course of at least fifty (50) hours, unless otherwise exempt under this Section.

63.02-34 **Provider** is any entity, agency, facility, or individual who offers or plans to offer any in-home or community support services.

63.02-35 **Representative** is an individual responsible for managing Attendant Services on behalf of a Consumer using the consumer-directed option. The Representative must meet the qualifications and requirements described in Section 63.08-2(H).

63.02-36 **Residential Care Facility (RCF)** is a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services, including housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. Residential Care Facilities do not include a licensed nursing home or a supported living arrangement certified by the Department for behavioral and developmental services.

63.02-37 **Respite Care** are those services provided at home or in a facility to temporarily relieve the family or other caregivers who usually provide such services to the Consumer.

63.02-38 **Service Coordination Agency (SCA)** is an organization that has the statewide capacity to provide care coordination and Skills Training to eligible Consumers under this Section. In addition to care coordination and Skills Training, the SCA is responsible for administrative functions, including but not limited to, maintaining Consumer records, billing, conducting internal utilization and quality assurance activities, and meeting the reporting requirements of the Department.

63.02-39 **Service Order** is the document provided by the SCA to the Direct Care Provider that includes information on the type, amount, and frequency of services to be provided to the Consumer. The Service Order specifies the tasks authorized by the ASA in the Authorized Plan of Care.

63.02-40 **Signature:** Effective with the implementation of the computerization of the Medical Eligibility Determination (MED) Form, signature of the registered nurse assessor or the Service Coordination Agency staff will equate with "login" onto the appropriate electronic system.

63.02-41 **Significant Service Change** is a major change in the Consumer's status that is not self-limiting, impacts more than one area of their health status, and requires multidisciplinary review or revision of the Authorized Plan of Care

63.02-42 **Skills Training** is a service that provides Consumers and Representatives with the information and skills necessary to carry out their responsibilities when choosing to participate in the consumer-directed option, who have attained authorization for Attendant services. This is a required service for Consumers utilizing the consumer-directed option.

63.02-43 **Unstable Medical Condition** exists when the Consumer's condition is fluctuating in an irregular way and/or is deteriorating and affects the Consumer's ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment, and management at least once every eight (8) hours is required. An Unstable Medical Condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and Authorized Plan of Care adjustments must be documented in the medical record. Not included in this definition is the loss of function resulting from a temporary disability from which full recovery is expected.

63.03 ELIGIBILITY

63.03-1 General and Specific Eligibility Requirements. To be eligible for services under this Section, a Consumer must:

A. Be at least 18;

B. Be a resident of Maine;

C. Have Liquid Assets of no more than $50,000, or for couples have assets of no more than $75,000;

EXCEPTION: Consumers who received services under 14-197 C.M.R. Chapter 11 (Consumer Directed Personal Assistance Services) on June 30, 2023, are not subject to the Liquid Assets eligibility requirement.

D. Lack personal and/or financial resources for in-home services as determined by a Consumer's Eligibility in subsection 63.08-1 and Consumer Payment in subsection 63.12;

E. Be ineligible for the following services:

(1) Private Duty Nursing and Personal Care Services, 10-144 ch. 101, ch, II, Section 96, except as otherwise provided in this Section;

(2) Day Health Services, 10-144 ch. 101, ch. II, Section 26;

(3) Consumer Directed Attendant Services, 10-144 ch. 101, ch. II, Section 12; and

(4) Home and Community Based Services Waivers, 10-144 ch. 101, ch. II, Sections 18, 19, 20, 21, 29.

F. Not be a participant of the following state-funded services:

(1) Adult Day Services, 10-149 C.M.R. ch. 5, Section 61;

(2) Congregate Housing Services Program, 10-149 C.M.R. ch.5, Section 62;

(3) Respite Care for People with Alzheimer's or Related Disorders, 10-149 C.M.R. ch. 5, Section 68; and

(4) Homemaker Program, 10-149 C.M.R. ch. 5, Section 69.

G. Not be a resident of a licensed residential setting. The Consumer's residence may be the Consumer's home or a transitional living program. Personal Care services under this program cannot be delivered in an Adult Family Care Home (AFCH) setting or other Licensed Assisted Living Facility which is currently reimbursed by state and/or federal funds for providing Personal Care Services; and

H. Agree to pay the monthly calculated Consumer payment directly or through their Representative.

63.03-2 Medical and Functional Eligibility Requirements

Applicants for HBSS must meet the medical and functional eligibility requirements as set forth in this Section and documented on the Medical Eligibility Determination (MED) Form. Medical eligibility will be determined using the MED Form. A person meets the medical eligibility requirements for a particular level of care if they require a combination of assistance with the following services: Activities of Daily Living, Instrumental Activities of Daily Living, and Nursing Services; or for Level V, Medication Administration seven (7) days prior to assessment. The requirements for each level of care are defined below. The clinical judgment of the Department's Assessing Services Agency shall be the basis of the scores entered on the MED Form.

A. Level I

A person meets the medical eligibility requirements for Level I of Home Based Supports and Services if they require at least one (1) of the following:

(1) Cueing seven (7) days per week for eating, toilet use, bathing, and dressing;

(2) Limited Assistance and a One-Person Physical Assist with at least two (2) ADLs plus physical assistance with at least one (1) IADL;

(3) Limited Assistance and a One-Person Physical Assist with at least one (1) ADL plus physical assistance with at least two (2) IADLs;

(4) Limited Assistance and a One-Person Physical Assist with at least three (3) ADLs;

(5) One (1) of the nursing services listed in 63.02-29(A)-(K), at least once per week, that are or otherwise would be performed by or

under the supervision of a registered nurse and Limited Assistance plus a One-Person Physical Assist with at least two (2) ADLS;

(6) Two (2) of the nursing services listed in 63.02-29(A)-(K), at least once per week, that are or otherwise would be performed by or under the supervision of a registered nurse and Limited Assistance plus a One-Person Physical Assist with at least one (1) ADL; or

(7) One (1) of the nursing services listed in 63.02-29(A)-(K), at least once per week, that are or otherwise would be performed by or under the supervision of a registered nurse and Limited Assistance plus a One-Person Physical Assist with at least one (1) ADL plus physical assistance with at least one (1) IADL.

B. Level II

A person meets the medical eligibility requirements for Level II of Home Based Supports and Services if they require:

(1) At least one (1) of the nursing services listed in 63.02-29(A)-(P), at least once per month, that are or otherwise would be performed by or under the supervision of a registered nurse; and

(2) At least one (1) of the following:

(a) Cueing seven (7) days per week for eating, toilet use, bathing, and dressing; or

(b) Limited Assistance and a One-Person Physical Assist with at least two (2) ADLS.

C. Level III

A person meets the medical eligibility requirements for Level III of Home Based Support and Services if they require:

(1) At least Limited Assistance and One-Person Physical Assist in two (2) of the following five (5) ADLS: bed mobility, transfer, locomotion, eating or toileting; and

(2) Limited Assistance and a One-Person Physical Assist with at least three (3) ADLs.

D. Level IV

A person meets the medical eligibility requirements for Level IV of Home Based Support and Services if they meet the medical eligibility requirements for nursing facility level of care set forth in 10-144 C.M.R. ch. 101, ch. II, Section 67, § 67.02-3, Nursing Facility Services.

E. Level V

A person meets the medical eligibility requirements for Level V if at least one (1) of the following criteria is met:

(1) The person requires daily assistance with medication administration for routine prescription medications delivered by a Certified Residential Medication Aid and physical assistance with at least two (2) IADLs;

(2) The persons requires daily assistance with medication administration for routine prescription medications delivered by a Certified Residential Medication Aid and physical assistance with at least one (1) ADL; or

(3) The persons meets eligibility for Level I, II or III under this Section and resides in a facility that meets the requirements of being a state funded Licensed Assisted Living Agency.

63.03-3 Continued Eligibility:

A. If the assessment for continued eligibility indicates medical eligibility for a MaineCare program and potential financial eligibility for MaineCare, Consumers will be given written notice that the Consumer has up to thirty (30) days to file a MaineCare application.

B. If HBSS is currently being received, services shall be discontinued if the Department's Office of Family Independence notice is not received within thirty (30) days of the assessment date indicating that a financial application has been filed.

C. Services shall also be discontinued if, after filing the application within thirty (30) days, the application requirements have not been completed in the time required by MaineCare policy.

D. No further notice of termination is required in order for the termination to be effective as soon as MaineCare eligibility is established. Services

under this section will not be terminated if MaineCare eligibility is denied, unless otherwise indicated in 63.03-3(C).

63.03-4 Additional Requirements for Consumer-Directed Option

For a Consumer to direct their own services under the consumer-directed option without the use of a Representative, the Consumer must have Cognitive Capacity, as assessed on the MED Form, to be able to self-direct their Attendant(s). The ASA will assess Cognitive Capacity as part of each Consumer's eligibility determination using the MED findings. Minimum MED Form scores are:

A. Decision making skills: a score of 0 or 1;

B. Making self-understood: score of 0, 1 or 2;

C. Ability to understand others: score of 0, 1 or 2;

D. Self-performance of managing finances: a score of 0, 1, or 2; and

E. Support for managing finances: a score of 0, 1, 2 or 3.

A Consumer not meeting the specific scores detailed above during their eligibility determination will be presumed not able to self-direct without the use of a Representative under this Section.

63.04 DURATION OF SERVICES

Each Consumer may receive as many HBSS covered services as are required within the limitations and exceptions as described below. All HBSS under this Section require~~s~~ prior authorization from the Department or its Assessing Services Agency. Beginning and end dates of a Consumer's medical eligibility determination period correspond to the beginning and end dates for Home Based Supports and Services coverage of the plan of care authorized by the Assessing Services Agency or the Department. The services provided must be reflected in the service plan and based upon the authorized covered services documented in the care plan summary of the MED Form.

63.04-1 Suspension

Services may be suspended for up to sixty (60) days. If the circumstances requiring suspension extend beyond sixty (60) days, the Consumer's eligibility in the program will be terminated.

After services are terminated, a Consumer will need to be reassessed to determine medical eligibility for services and be subject to the requirements of

the waiting list, provided in Section 63.07-2. If the SCA does not become aware until after sixty (60) days of the circumstances requiring suspension, the Consumer will be terminated as of the date the SCA verifies the change in status.

Upon discharge from a hospital or institutional care facility, the Consumer's previous level of service will resume until a reassessment is conducted. The reassessment will be conducted within two (2) weeks following the Consumer's discharge from the hospital or institutional care facility.

63.04-2 Service Reduction, Denial or Termination

A. HBSS may be reduced, denied, suspended or terminated under the following circumstances; only the Department may terminate HBSS.

(1) The individual does not meet or declines eligibility requirements;

(2) The individual declines services;

(3) The individual is eligible to receive services under a MaineCare program, including any MaineCare Home or Community Based waiver program or a State funded long term services and supports program;

(4) The health or safety of the individual providing services is endangered by the Consumer or Representative;

(5) Services have been suspended for more than sixty (60) days;

(6) The Consumer refuses personal care or nursing services;

(7) The Consumer has failed to make their calculated monthly co-payment within thirty (30) days of receipt of the co-pay bill;

(8) The Consumer or Representative gives fraudulent information to the Department or Authorized Agency, including, but not limited to assessment information and reporting, payroll records, and all other record keeping documents;

(9) The Consumer is eligible to receive home health services for some or all of the services authorized under this Section from Medicare or another third party payer;

(10) The availability of informal and formal supports, including public and private sources, duplicate the services provided under this Section;

(11) The Consumer is using program funds to pay the Attendant to complete tasks outside the covered services described in Section 63.05;

(12) The Consumer or Representative fails to demonstrate the skills necessary to successfully manage their personal health maintenance, including management of the Attendant in compliance with this Section;

(13) The Consumer endorses or attempts to endorse a check that is made payable to the Attendant;

(14) The Consumer fails to carry out their responsibilities for FICA withholding, unemployment insurance or worker's compensation insurance;

(15) The Consumer's Authorized Plan of Care is reduced to match the Consumer's needs as identified in the Consumer's most recent MED Assessment, subject to the limitations of the program; or

(16) HBSS funding has been reduced.

B. Notice of any denial, termination, or reductions of services must be provided in accordance with 10-149 C.M.R. ch. 5, Section 40.

63.04- 3 Violation of Requirements

A. In the event that a Consumer is found to have used program funds in violation of the requirements of this subsection, the Consumer must reimburse the Authorized Agent for all such funds before being subsequently considered for services under this Section.

B. In the event that services have been denied or terminated by the Authorized Entity or the Department for fraud, waste and abuse reasons included in this subsection, such actions will be a factor in determining eligibility in any subsequent application for services under this Section.

63.04-4 Denial of Consumer-Direction

The ASA, SCA or Department, as appropriate, may deny or terminate the Consumer from receiving consumer-directed services for the following reasons:

A. The Consumer or Representative provides fraudulent or repeatedly inaccurate information to the Department, ASA, SCA or Fiscal Intermediary in connection with obtaining or receiving services,

including the submission of time sheets that are not accurate of the services provided;

B. The Department, the SCA or the ASA documents that Representative harasses, threatens or endangers the safety of the Consumer or individuals delivering services; or

C. The SCA documents that the Consumer or the Representative fails to hire or manage an Attendant consistent with the requirements of this Section, including directing an Attendant to provide services that are inconsistent or not covered by the Authorized Plan of Care or hiring an Attendant who does not have the ability provide Attendant Services as defined by the Authorized Plan of Care.

Prior to and as part of denying or terminating services specific to the consumer-directed option, the SCA will work to transition the Consumer to another Representative or to agency services, as appropriate.

Notice of any denial or termination services must be provided in accordance with 10-149 C.M.R. ch. 5, Section 40.

63.04-5 Out of State Services

Personal care or Attendant Services provided to a Consumer while the Consumer is out of state must be approved by the SCA and may not exceed fourteen (14) consecutive days. The SCA will review the Authorized Plan of Care and determine if all ADL and IADL services are needed by the Consumer while out of state. The Consumer is allowed thirty (30) days total of out of state services per fiscal year. This section applies only when the service is being provided by an agency licensed or registered in Maine or provided by an Attendant under the consumer-directed option. The Consumer must continue to meet all other program requirements.

63.05 COVERED SERVICES

Covered services are available for Consumers meeting the eligibility requirements set forth in Section 63.03. All covered services require prior authorization by the Department, or its Assessing Services Agency, consistent with this Section, and are subject to limitations. The Authorized Plan of Care shall be based upon the Consumer's assessment outcome scores recorded on the Department's MED Form, according to its definitions, and the timeframes therein and the task time allowances defined in the appendix to this section.

Services provided must be required to meet the identified needs of the Consumer, based upon the outcome scores on the MED Form, and as authorized in the plan of care. Coverage will be denied

if the services provided are not consistent with the Consumer's Authorized Plan of Care. The Department may also recoup payment from the Service Coordination Agency or Licensed Assisted Living Agency for inappropriate services provision, as determined through post payment review. The Assessing Services Agency has the authority to determine the plan of care, which shall specify all services to be provided, including the number of hours for each covered service.

The Assessing Services Agency will use Task Time Allowances set forth in the appendix to this section to determine the time needed to complete authorized ADL tasks for the plan of care not to exceed the program limits specified in 63.07.

Covered services are as follows:

63.05-1 Care Coordination Services

Care Coordination services are provided by the SCA (through the care coordinator) to help the Consumer access services in the Authorized Plan of Care. Care Coordination Services require the SCA to engage in Person-Centered Planning. Care Coordination Services assist Consumers in receiving appropriate, effective, and efficient services, which allows the Consumer to retain or achieve the maximum amount of independence possible and desired. Care Coordination Services are designed to assist the Consumer with identifying immediate and long-term needs so that the Consumer is offered choices in service delivery based on their needs, preferences, and goals.

The SCAs must provide the following Care Coordination Services to Consumers:

A. Initial contact with the Consumer or the responsible party, by telephone or other appropriate method, within two (2) business days of notification of authorization by the ASA of Care Coordination Services to discuss the Authorized Plan of Care, service delivery options, choice of Provider(s), preferred frequency of service delivery based on the Consumer's needs consistent with the timeframe of the service authorization (i.e. weekly/monthly), clarify issues, and answer questions;

B. For Consumer's receiving Personal Care Services through an agency, face-to-face monitoring with the Consumer at least annually to monitor the Consumer's overall health status by completing the Health and Welfare Tool and following up on identified needs and issues;

C. For Consumers authorized to receive Attendant Services through the consumer-directed option, face-to-face monitoring with the Consumer at least every six (6) months to monitor the Consumer's overall health status by completing the Health and Welfare Tool and following up on identified needs and issues;

D. Skills training prior to the start of consumer-directed services. Initial skills training must occur within thirty (30) calendar days from when the Consumer requests to direct their own services. The SCA may extend the thirty (30) day time frame for good cause (e.g. hospitalization of the Consumer or Representative). A competency-based assessment may be performed in lieu of skills training for Consumers who have previously completed such training;

E. Advocating on behalf of the Consumer for access to appropriate community resources and services by providing information, making referrals and otherwise facilitating access to these supports, including employment and support;

F. Implementing the Authorized Plan of Care and coordinating of service Providers who are responsible for delivery of services pursuant to the Consumer's Authorized Plan of Care and identified needs; Maintaining contacts, on behalf of the Consumer, with family members, designated representative, guardian, Providers of services or supports and the Assessing Services Agency to ensure the continuity of care and coordination of services;

G. Monitoring the Consumer's receipt of services and reviewing the Authorized Plan of Care by contacting the Consumer at least once per month, or more frequently upon request by the Consumer. Monitoring calls may be reduced to a lesser frequency but not less than quarterly if the Consumer requests less frequent calls and there is documentation in the record to support this choice. Monitoring may be done by telephone unless an in-person visit is needed to be effective as determined by the SCA or the Department;

H. Assessing the Consumer/Provider relationship, including whether agency or Attendant duties are being performed satisfactorily; in addition assessing if the Attendant is trained adequately or if additional training is needed;

I. Calculating the Consumer's co-payment based on the estimated copayment determined by the Assessing Services Agency and receipt and review of the documented dependent allowances and Disability Related Expenses. Consumers receiving services under this Section may be selected for verification of Income and assets;

J. Making referrals for reassessments at least twenty-one (21) days prior to the end of the eligibility period and based upon a Significant Service Change in the Consumer's condition;

K. Beginning discharge planning on the first day of services. A discharge plan will enable the Consumer to transition to other services, as appropriate;

L. In the event a Consumer experiences an unexpected need, the Service Coordination Agency has the authority to adjust the frequency of services under the Authorized Plan of Care, in order to meet the needs, as long as the total Authorized Plan of Care hours for the eligibility period are not exceeded;

M. In the event a Consumer experiences an Acute/Emergency Episode, the Service Coordination Agency has the authority to adjust the Authorized Plan of Care up to 15% of the monthly authorized amount not to exceed the applicable cap. Services resulting from an Acute/Emergency Episode may not continue beyond fourteen (14) days and the Service Coordination Agency must request a reassessment on the date the increase is implemented;

N. Issuing notice to reduce, deny or terminate HBSS services; and

P. Other administrative tasks including, but not limited to:

(1) Processing assessment packets;

(2) Maintaining Consumer records;

(3) Tracking and reporting services;

(4) Preparing the Service Coordination Agency budget and processing of claims to the Department;

(5) Contracting with service Providers including Fiscal Intermediaries and requiring compliance by any and all sub-contractors with policy requirements; and conducting required utilization review activities.

(6) Reimbursing subcontracted home care Providers;

(7) Preparing information as required by the Department; and

(8) Following mandated reporting requirements in accordance with 22 M.R.S. § 3477.

63.05-2 Homemaking Services

Homemaking services means services to assist a Consumer with their general

housework, meal preparation, grocery shopping, laundry, and incidental personal hygiene and dressing. If the Consumer is receiving care at Level I, IADL tasks may constitute up to, but shall not exceed, two (2) hours per week of authorized services.

63.05-3 Personal Care Services

Personal Care Services consist of services to aid Consumers with ADLs and IADLs and Level V Medication Administration. Personal Care Services may be delivered by a Personal Care Agency or an Attendant through the consumer-directed option.

The consumer-directed option is a choice offered to Consumers to manage their Attendant services. Specifically, the Consumer hires, discharges, trains, schedules, and supervises the Attendant(s) providing services. A Consumer who chooses to engage in the consumer-directed option is considered the employer of their Attendant(s).

A. ADL services include bed mobility, transfer, locomotion, eating, toilet use, bathing and personal hygiene, dressing, and Health Maintenance Activities. When authorizing a plan of care that includes Personal Care Services the Assessing Services Agency will use the task time allowances specified in the appendix attached to this Section not to exceed limits specified elsewhere in this Section. ADL services may be provided in the Consumer's residence or at an adult day services program.

B. IADL services include meal preparation, grocery shopping, routine housework and laundry, which are directly related to the Consumer's Authorized Plan of Care.

(1) These tasks must be performed in conjunction with personal support ADL services or Level V Medication Administration services delivered by a Certified Residential Medication Assistant.

(2) These IADL tasks would otherwise be normally performed by the Consumer if they were physically or cognitively able to do so, and it must be established by the Assessing Services Agency that there is no family member or other person available and willing to assist with these tasks.

(3) If the Consumer is receiving care at Level I, IADL tasks may constitute up to, but shall not exceed, two (2) hours per week of authorized Personal Care Services.

(4) If the Consumer is receiving care at Level II, IADL tasks may constitute up to, but shall not exceed, three (3) hours per week of authorized Personal Care Services.

(5) If the Consumer is receiving care at Level III, IADL tasks may constitute up to, but shall not exceed, four (4) hours per week of authorized Personal Care Services.

(6) If the Consumer is receiving care at Level IV, there are no limitations on IADLs, the total monthly cost of services authorized may not exceed the lesser of the cost of the monthly plan of care authorized by the Assessing Services Agency or 80% of the average cost of MaineCare nursing facility level of care established by the Department.

(7) If the Consumer is receiving care at Level V, IADL tasks may constitute up to, but shall not exceed, four (4) hours per week of authorized Personal Care Services.

(8) If the Consumer is receiving care at Level V, Medication Administration may constitute up to, but shall not exceed, three (3) medication pass visits per day for a total of twenty-one (21) medication passes weekly.

C. All Personal Care Services may be used for ADLs if necessary.

D. No individual providing this service may be reimbursed for more than forty (40) hours of care per week for an individual Consumer or for a household in which there is more than one Consumer.

E. When authorizing a Consumer's Authorized Plan of Care, Personal Care Services for ADLs must be authorized in accordance with the Task Time Allowances not to exceed programs caps or limits specified elsewhere in this section (see appendix to this Section). If these times are not sufficient when considered in the light of a consumer's unique circumstances as identified by the Authorized Agent, the Authorized Agent may make an appropriate adjustment as long as the authorized hours do not exceed limits established for Consumer's level of care. Task time allowances will consider the possibility for concurrent performances of activities and tasks listed. Services listed in the Task Time Allowances that are not covered services under this Section may not be authorized.

F. Except for Level V, a "one Hour" PSS visit is a one–hour visit to deliver Personal Care Services and Health Maintenance Activities to a Consumer, no more than once per day. This service may be authorized

up to seven (7) days per week. If a person requires more than one (1) hour of personal care service on a given day, then the PSS services must be billed using the quarter-hour units.

63.05-4 Handyman/Chore Services

Chore services assist a Consumer with occasional heavy-duty cleaning, raising and lowering of combination screen/storm windows, repairs and similar minor tasks to eliminate safety hazards in the environment.

63.05-5 Home Health Services

Home health services assist a Consumer with health and medical and ADL needs as identified on the MED Form and authorized by the Assessing Services Agency. These include nursing; home health aide and certified nursing assistant services; physical, occupational, and speech therapy; and medical social services, when no other method of third-party payment is available. Home Health services may only be purchased from licensed agencies and shall be reimbursed at an hourly rate. When authorizing personal care services provided by a HHA or CNA, the Assessing Services Agency must use the task time allowances set forth in the appendix attached to this Section to authorize the time covered to complete authorized ADL and IADL tasks for the Authorized Plan of Care not to exceed the program caps or limits specified in 63.07.

63.05-6 Respite

Respite Services are provided to Consumers, furnished on a short-term basis because of the absence of or need for relief of the caregiver. This service may be provided at home, in a licensed Adult Day Program, or in an institutional setting.

The annual cost of respite services may not exceed an annual cap as established by the Department and is included in the Consumer's annual care plan cost limit. A Consumer receiving MaineCare's Private Duty Nursing and Personal Care Services pursuant to 10-144 ch. 101, ch. II, Section 96, may receive respite services to the extent that budgeted resources permit and to the extent that there is no waiting list under this Section.

63.05-7 Transportation.

Personal Support Specialists, certified nursing assistants, home health aides and homemakers may escort or transport a Consumer only to carry out the Authorized Plan of Care. Any individual providing transportation must hold a valid State of Maine driver's license for the type of vehicle being operated. All Providers of transportation services shall maintain adequate liability insurance coverage for the type of vehicle being operated. Escort services may be provided

only when a Consumer is unable to be transported alone, there are no other resources (family or friends) available for assistance, and the transportation agency can document that the agency is unable to meet the request for service. Reimbursement shall only be made for mileage in excess of ten (10) miles per single trip on a one-way trip for transportation provided by personal care assistants, homemakers, or other home health Providers in the course of delivering a covered service under this section.

63.05-8 Adult Day Services

Adult day services are furnished by Providers who are licensed and certified by the Department.

63.05-9 Home Modification

Home modifications are permitted to promote independent living and carry out the Authorized Plan of Care up to a lifetime cost of $3,000, and when there is no alternative source of funding.

63.05-10 Personal Emergency Response System (PERS)

A Personal Emergency Response System is an electronic device which enables certain high-risk individuals to secure help in the event of an emergency. PERS services may be provided to those individuals who live alone, or who are alone for significant parts of the day, who are capable of using the system, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The use of the PERS will result in a reduction of authorized hours that are equal to the cost of the service.

63.05-11 Skills Training

Skills training is a service that provides Consumers and Representatives with the information and skills necessary to carry out their responsibilities when choosing to participate in the consumer-directed option. This is a required service for Consumers utilizing the consumer-directed option.

Skills Training services instruct the Consumer in the management of Attendant Services under the consumer-directed option. Instruction in management of Attendant Services includes instruction in recruiting, interviewing, selecting, training, scheduling, discharging, and directing a competent Attendant in the activities in the Authorized Plan of Care and requirements under this Section. Skills Training must include information on how to report suspected abuse, neglect, and exploitation to Adult Protective Services.

63.06 NON-COVERED SERVICES

The following services are non-covered services:

63.06-1 Rent and Board;

63.06-2 Services for which the cost exceeds the limits described in Section 63.05 and 63.07, except as described in 63.07-1;

63.06-3 Personal Care Services delivered in a Residential Care Facility, a supported living arrangement certified by the Department for behavioral and developmental services or a licensed or unlicensed assisted living program except for those that meet the definition of a Licensed Assisted Living Agency);

63.06- 4 Services provided by anyone prohibited from employment under the following:

A. A Personal Support Specialist or homemaker who is prohibited from employment pursuant to 22 M.R.S. §§ 1717(3), 2149-A(2), 7851(4), 8606; or

B. A certified nursing assistant who is prohibited from employment pursuant to 22 M.R.S. § 1812-G(6);

63.06-5 Homemaker and handyman/chore services not directly related to medical need pursuant to Section 63.05-2 and -4;

63.06-6 Those services which can be reasonably obtained by the Consumer by going outside their place of residence;

63.06-7 Travel time and mileage by the Authorized Agent, Authorized Agent's staff, and/or the assistant to and from the Consumer's residence;

63.06-8 Mileage for Personal Assistants;

63.06-9 Supervisory visits made for the purpose of supervising home health aides, certified nursing assistants, or personal care assistants;

63.06-10 Custodial or supervisory care;

63.06-11 Respite services when delivered by the Consumer's spouse;

63.06-12 Personal Care Services when delivered by the Consumer's guardian, conservator, power of attorney or other legally responsible individual;

63.06-13 Services provided not in the presence of the Consumer unless in the provision of covered; IADLs, such as grocery shopping or laundry while the Consumer remains at home;

63.06-14 Venipuncture, as a stand-alone service.

63.06-15 Any reimbursement for hours of services in excess of the maximum authorized service amount;

63.06-16 Services in excess of forty (40) hours per week provided by an individual worker to any individual Consumer or household;

63.06-17 Services provided out of state except as otherwise allowed in Section 63.04-5;

63.06-18 Personal Care or Attendant Services provided to a Consumer receiving respite in an institutional setting; and

63.06-19 Reimbursement for HBSS provided by a Consumer who receives personal care services under this Section or any other MaineCare or state-funded program.

63.07 LIMITS

The total monthly cost of Home Based Supports and Services may be capped by the Department. The limits are as follows:

63.07-1 For Consumers accessing Adult Day Services reimbursed by HBSS funds, the caps may be exceeded by an amount determined by the Department.

63.07-2 For Consumers classified for Level I level of care, the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level I" cap, established by the Department.

63.07-3 For Consumers classified for Level II level of care, the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level II" cap established by the Department.

63.07-4 For Consumers classified for Level III level of care, the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level III" cap established by the Department.

63.07-5 For Consumers classified for Level IV level of care, the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or 80% of the average cost of MaineCare nursing facility level of care established by the Department.

63.07-6 For Consumers classified for Level V level of care, the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level V" cap established by the Department.

63.08 POLICIES AND PROCEDURES

63.08-1 Eligibility Determination

An eligibility assessment, using the Department's approved MED Form, shall be conducted by the Department or the Assessing Services Agency. All other Home Based Supports and Services require eligibility determination and authorization by the Assessing Services Agency to determine eligibility pursuant to Section 63.03.

A. The Assessing Services Agency will accept verbal or written referral information on each prospective new Consumer, to determine appropriateness for an assessment. When funds are available to conduct assessments, appropriate Consumers will receive a face-to-face medical eligibility determination assessment at their current residence within the time requirement specified by the Office of Aging and Disability Services (OADS) in the contract, of the date of referral to the Assessing Services Agency. All requests for assessments shall be documented indicating the date and time the assessment was requested and all required information provided to complete the request. The individual conducting the assessment shall be a registered nurse (RN) and will be trained in conducting assessments and developing an Authorized Plan of Care with the Department's approved MED Form. The assessor shall, as appropriate within the exercise of professional judgment, consider documentation, perform observations and conduct interviews with the long-term care Consumer, family of Consumers, direct care staff, the Consumer's physicians and other individuals and document in the record of the assessment all information considered relevant in their professional judgment. The RN assessor's findings and scores recorded in the MED Form shall be the basis for establishing eligibility for services and the Authorized Plan of Care. The anticipated costs of covered services to be provided under the Authorized Plan of Care must conform to the limits set forth in Section 63.05 and 63.07.

B. The Assessing Services Agency shall inform the Consumer of available community resources and authorize a plan of care that reflects the identified needs documented by scores and timeframes on the MED Form, giving consideration to the Consumer's living arrangement, informal supports, and services provided by other public and private funding sources. HBSS provided to two (2) or more Consumers sharing living arrangements shall be authorized by the Assessing Services Agency with consideration to the economies of scale provided by the group living situation, according to limits in Section 63.05 and 63.07. The Assessing Services Agency shall assign the appropriate level of care for which the Consumer is eligible (see Section 63.03-2) and authorize a plan of care based upon the scores and findings recorded in the MED assessment.

The covered services to be provided in accordance with Level I, II, III, IV or V and the Authorized Plan of Care shall:

(1) Not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the financial caps established by OADS for the corresponding level of care; and

(2) Be prior authorized by the Department or its Assessing Services Agency.

The assessor shall approve an eligibility period for the Consumer, based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment. An initial eligibility period for Level IV shall not exceed three (3) months.

C. The assessor will provide a copy of the Authorized Plan of Care, in a format understandable by the average reader, a copy of the applicable eligibility notice, release of information and the appeal hearing rights notice, to the Consumer at the completion of the assessment. The assessor will inform the Consumer of the estimated co-payment and the cost of services authorized.

D. Except for those Consumers eligible to receive services under Level V of this Section, the assessor shall forward the completed assessment packet to the Department's authorized Service Coordination Agency within seventy-two (72) hours of the medical eligibility determination and authorization of the plan of care. For those Consumers eligible to receive services under Level V of this Section, the assessor shall forward the completed assessment and plan of care to the appropriate Licensed Assisted Living Agency.

E. For Level I-IV, the Service Coordination Agency shall contact the Consumer within the time required under their contract with OADS of transmission of the MED assessment and Authorized Plan of Care. The Service Coordination Agency shall assist the Consumer with locating Providers and obtaining access to services authorized on the care plan summary by the Assessing Services Agency or the Department. The Service Coordination Agency shall implement and coordinate services with the Provider agency or independent contractor using service orders, as well as, monitor service utilization and assure compliance with this Section.

F. For Levels I-IV, the Provider or independent contractor shall request through the Service Coordination Agency any change in the Authorized Plan of Care. The Service Coordination Agency shall be responsible to assure that the authorized service plan shall not exceed the lesser of the

Authorized Plan of Care authorized by the Assessing Services Agency or the financial cap established by the Department for the level of Home Based Supports and Services authorized.

G. For Levels I-IV, the Direct Care Provider or independent contractor contracted by the Service Coordination Agency to provide skilled nursing services shall develop a nursing plan of care, which shall be reviewed and signed by the recipient's physician. It shall include the personal care and nursing services authorized by the Assessing Services Agency or the Department, and the medical treatment plan signed by the recipient's physician. A copy must be forwarded to the Service Coordination Agency at no additional charge.

H. For Levels I-IV, the Service Coordination Agency will complete standardized referral requests for reassessment and submit the requests to the Department or the Assessing Services Agency at least twenty-one (21) days prior to the reassessment due date. The most up to date status of the Consumer as reported by the care coordinator, care monitor and any MDT findings must be included in the reassessment request.

I. For Level V, the Licensed Assisted Living Agency will complete standardized referral requests for reassessment and submit the requests to the Department or the Assessing Services Agency at least five (5) days prior to the reassessment due date. The most up to date status of the Consumer must be included in the reassessment request.

63.08-2 Waiting List

A. When availability of services exceeds six (6) months the Assessing Services Agency will establish a statewide interest list for assessments. As funds become available, Consumers will be assessed on a first come, first served basis.

B. For Consumers found ineligible for HBSS, the Assessing Services Agency will inform each Consumer of alternative services or resources and offer to refer the person to those other services.

C. When funds are not available to serve new Consumers who have been assessed for eligibility or to increase services for current Consumers, a waiting list will be established for Levels I-IV by the Department. For Consumers on the waiting list, eligibility will be advisory only. As funds become available Consumers will be taken off the list and served on a first come, first served basis and eligibility will be determined and a plan of care authorized.

D. When there is a waiting list, the Assessing Agency will inform each Consumer who is placed on the waiting list of alternative services or resources and offer to refer the person to those other services.

E. Consumer names may be removed from the waiting list at the request of the Consumer or if the Department determines that another funding source is available to the Consumer, or the Consumer has entered a hospital, Residential Care Facility or nursing facility for longer than thirty (30) days or upon the death of the Consumer.

63.08-3 Reassessment and Continued Services

A. For all Consumers under this Section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and authorization of services is required and must be conducted within the timeframe of twenty-one (21) days prior to and no later than the reassessment due date. HBSS payment ends with the reassessment date, also known as the end date.

If the reassessment date for a Consumer occurs within the sixty-day suspension period, that reassessment date will be extended for as long as services are suspended, but no later than the last day of the sixty (60) day suspension period. If services are suspended beyond sixty-days, the Consumer's eligibility in the program will be terminated. After services are terminated, a Consumer will need to be reassessed to determine medical eligibility for services and will be placed on the waiting list and will be subject to the waiting list requirements.

B. An individual's specific needs for Home Based Supports and Services must be reassessed at least every twelve (12) months, or earlier if indicated by the clinical judgment of the nurse assessor;

C. Unscheduled reassessments due to financial changes that may potentially result in a change in program funding source must be requested by the Service Coordination Agency or the Licensed Assisted Living Agency.

D. Unscheduled financial reassessments may be completed by the Service Coordination Agency or Licensed Assisted Living Agency when a spouse or significant other household member passes away or there has been a documented change of 20% or greater in the asset or Income level of the household;

E. Unscheduled reassessments due to eligibility or service needs must be justified with consideration given to any MDT findings and requested by the Service Coordination Agency.

F. Significant Change reassessments will be requested by the Service Coordination Agency or the Licensed Assisted Living Agency). The Assessing Services Agency will review the request and the most recent assessment to determine whether a reassessment is warranted and has the potential to change the level of care or alter the Authorized Plan of Care.

G. For Consumers currently under the appeal process pursuant to 10-149 C.M.R. ch. 5, Section 40, reassessments will not be conducted unless the Consumer experiences a Significant Change or has an Acute/Emergency Episode.

63.08-4 Rates

The Department contracts with the Services Coordination Agency vendors and established rates are outlined within the contract.

63.08-5 Appeals

A Consumer may appeal the Department adverse actions through the Department's appeals process pursuant to 10-149 C.M.R. Chapter 5, Section 40 (General Administrative Requirements for all Parties), within sixty (60) days of the date of the notice of adverse action.

63.09 PROFESSIONAL AND OTHER QUALIFIED STAFF

63.09-1 Professional Staff

The following professional staff must be fully licensed, by the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure and approval to practice conditions. Professional staff also must have appropriate education, training, certification, and experience, as verified by the employing agency.

A. Registered Professional Nurse

B. Practical Nurse

C. Social Worker: A social worker must hold a Master's Degree from a school of social work accredited by the Council on Social Work Education.

D. Physical Therapist: A physical therapist who meets the requirements and the qualifications set forth in 10-144 C.M.R. ch. 101, ch. II, Section 85 may provide physical therapy services.

E. Occupational Therapist: A registered occupational therapist who meets the requirements and the qualifications set forth in 10-144 C.M.R. ch. 101, ch. II, Section 68 may provide occupational therapy services.

F. Speech-Language Pathologist: A speech-language pathologist meeting the requirements and qualifications set forth in 10-144 C.M.R. ch. 101, ch. II, Section 109 may provide speech and language therapy services.

63.09-2 Other Qualified Staff

Other qualified staff members, other than professional staff defined above, must have appropriate education, training, certification, and experience, as verified by the employing agency.

A. Assessor

In order to determine medical eligibility for services under this subsection the assessor must:

(1) Hold a valid registered nurse (RN) license in the State of Maine; and

(2) Must be employed with the contracted Assessing Services Agency.

B Care Coordinator

In order to provide Care Coordination Services under this Section, a care coordinator must be employed by an enrolled Service Coordination Agency and attend annual mandated reporter and fraud, waste, and abuse trainings.

Prior to employment, the care coordinator must provide written evidence of one (1) of the following:

(1) Status as a licensed social service or health professional;

(2) Four years of education in the health or social services field and one year of community experience;

(3) Status as a registered occupational therapist who is licensed to practice as an occupational therapy in Maine; or

(4) Status as a certified occupational therapy assistant who is licensed to practice occupational therapy in Maine under the documented supervision of a licensed occupational therapist.

C. Home Health Aide

A home health aide must be listed on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and must not be prohibited from employment pursuant to 22 M.R.S. § 1812-G. Home health aides employed by a home health agency must comply with the Regulations Governing the Licensing and Functioning of Home Health Care Services, 10-144 C.M.R. ch. 119. A home health aide shall work under the direct supervision of a registered nurse.

D. Certified Nursing Assistant (CNA)

A CNA must be listed on the Maine Registry of Certified Nursing Assistants or Direct Care Workers and must not be prohibited from employment under 22 M.R.S. § 1812-G. A CNA shall work under the direct supervision of a registered nurse.

E. Personal Support Specialist (PSS)

A PSS must be employed by, or acting under a contractual relationship with, a licensed home health agency or by a registered personal care agency. A family member who meets the requirements of this Section may be a PSS and receive reimbursement for delivering personal care services. A Consumer's guardian, conservator or power of attorney may not be a PSS and receive reimbursement for delivering personal care services.

(1) All individuals employed as a PSS must:

(a) Undergo criminal background checks and checks on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and Maine APS Substantiation Registry. A PSS may not be employed by the Provider agency if they are prohibited from employment pursuant to 22 M.R.S. § 1717.

(b) An individual without the required training may be hired and reimbursed for delivering Personal Support

Services as long as the individual enrolls in a certified training program within sixty (60) days of hire and completes training and examination requirements within nine (9) months of employment and meets all other requirements. If the individual fails to pass the examination within nine (9) months, reimbursement for his or her services must stop until such time as the training and examination requirements are met. A PSS must meet one (1) of the following:

i. Hold a valid certificate of training for Certified Nursing Assistants and be listed on the Maine Registry of Certified Nursing Assistants;

ii. Hold a valid certificate of training, issued within the past three (3) years, for nurse's aide or home health aide training that meets the standards of the Maine State Board of Nursing assistant training program;

iii. If a CNA's status on the Maine Registry of Certified Nursing Assistants has become inactive, or an individual holds a valid certificate of training meeting the standards of the Maine State Board of Nursing assistant program issued more than three (3) years ago, the individual must pass the competency-based examination of didactic and demonstrated skills from the Department's approved Personal Support Specialist curriculum. A certificate of training as a personal care assistant/Personal Support Specialist will be awarded upon passing this examination;

iv. Hold a valid certificate of training as a Personal Support Specialist issued as a result of completing the Department approved Personal Support Specialist training curriculum and passing the competency-based examination of didactic and demonstrated skills. The training course must include at least fifty (50) hours of formal classroom instruction, demonstration, return demonstration, and examination. Tasks covered under this Section must be covered in the training; or

v. Be a Personal Support Specialist who successfully completed a Department-approved curriculum prior to September 1, 2003. Such individuals will be grandfathered as a qualified PSS.

(2) A newly hired PSS must participate in a new employee orientation as described below.

(a) A PSS, newly hired to an agency, who meets the Department's PSS training requirements, must receive an agency orientation. The training and certification documents must be on file in the PSS's personnel file.

(b) A newly hired PSS who does not yet meet the Department's training and examination requirements must undergo an eight (8) hour orientation that reviews the role, responsibilities, and tasks of the PSS. To meet the required eight (8) hours for orientation an agency may choose to use job shadowing for a maximum of two (2) hours of the eight (8) hour time requirement. The orientation must be completed by the PSS prior to the start of delivering services. The PSS must demonstrate competency to the employing agency in all required tasks prior to being assigned to a Consumer's home, with the exception of Health Maintenance Activities, whereby a PSS can demonstrate competency via on-the-job training once being assigned to a Consumer's home.

(3) Provider agency responsibilities include, but are not limited to, the following:

(a) Assuring that a PSS meets the training, competency, and other requirements of this Section; and

(b) Maintaining documentation of how each requirement is met in the PSS's personnel file, including: evidence of orientation when applicable; check of the CNA and Direct Care Worker Registry; criminal background check; and the verification of credentials including the certificate of training and/or verification of competency.

(c) Supervisory visits

i. Initial visit. A Provider agency supervisor must make an initial visit to a Consumer's home prior to the start of PSS services to develop and review with the Consumer the Authorized Plan of Care as authorized by the ASA and as ordered by the care coordinator.

ii. Scheduled supervisory visits. An agency employer will provide a PSS on-site supervision at least every six (6) months in a Consumer's residence to observe and verify PSS competency in the delivery of service. The documentation of supervisory visits shall be maintained in the PSS's employee file. More frequent or additional on-site supervision visits of the PSS occur at the discretion of the Provider agency as governed by its personnel policies and procedures.

iii. A Provider agency must develop and implement written policies and procedures that ensure a smoke- free environment. PSSs are not allowed to smoke, consume alcohol, or use controlled substances in the Consumer's home or vehicle during work hours.

iv. A Provider agency must develop and implement written policies and procedures that address abuse, neglect or misappropriation of a Consumer's property and that includes information on mandated reporting requirements.

(4) Recoup funds for services provided if the sub-contracted agency or Fiscal Intermediary did not provide required documentation to support qualifications of the agency, staff, Attendants or services billed.

(5) Ensure the quality of services and has the authority to determine whether a PSS agency or Consumer or Representative has the capacity to comply with all service requirements. Failure to meet standards must result in no-approval or termination of sub-contracts or memorandums of agreement for PSS services. Termination of a sub-contract cannot be appealed in accordance with 10-149 C.M.R. ch. 5, Section 40.

(6) An agency must provide documentation demonstrating compliance with these requirements upon request by the Service Coordination Agency, or Department, including OADS.

F. Attendant

(1) The following requirements apply to Attendants employed under the consumer-directed option:

(a) Attendants must be at least seventeen (17) years old;

(b) Attendants must demonstrate competency to the Consumer or Representative in all required tasks;

(c) Attendants will not be reimbursed for more than forty (40) hours of service per week; and

(d) Attendants must be paid through a qualified Fiscal Intermediary.

(2) The following individuals may not be reimbursed as Attendants under this Section:

(a) A Consumer's guardian, conservator or power of attorney;

(b) A Consumer's Representative as defined in 63.02-35;

(c) An individual who has an annotation of abuse, neglect, or misappropriation of property on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and the Maine APS Substantiation Registry;

(d) An individual prohibited from being hired by an agency pursuant to 22 M.R.S. § 1717; or

(e) An individual who receives Attendant or Personal Care Services as a Consumer under this Section or other MaineCare or state funded program.

(3) After the completion of Skills Training instruction, the Consumer or Representative shall train the Attendant on the job. Within a twenty-one (21) day probation period, the Consumer or

Representative will determine the competency of the Attendant on the job. At a minimum, based upon the Attendant's job performance, the Consumer or Representative will certify competence in the following areas:

(a) Ability to follow verbal or signed and written instructions and carry out tasks as directed by the Consumer or Representative;

(b) Disability awareness;

(c) Use of adaptive and mobility equipment;

(d) Transfers and mobility; and

(e) Ability to assist with Health Maintenance Activities.

(4) Satisfactory performance in the areas above will result in a statement of Attendant competency for each Attendant. This statement must be completed on a Department-approved form signed by the Consumer, submitted to the SCA, with a copy kept in the Consumer's record. The SCA may require that the Consumer or the Representative provide additional information or verification regarding the competency of an Attendant before or after hiring.

G. Skills Trainer

A Skills Trainer must:

(1) Have a high school degree or equivalent;

(2) Be an employee of the SCA; and

(3) Have the ability to teach the skills required for a Consumer to successfully utilize the consumer-directed option including information on recruiting, interviewing, selecting, training, scheduling and supervising a competent Attendant.

Requisite skills which must be documented by the SCA include the ability to effectively communicate with Consumers or Representatives, their families and other support staff; knowledge of program regulations and the principles of Consumer direction; and knowledge of community resources.

H. Representative

A Representative may manage Attendant Services for a Consumer under the consumer-directed option and shall not be compensated for the services provided under this Section. The Representative must be able to manage and direct program Attendant Services for the Consumer in accordance with the Consumer's preferences and meet all program requirements. The Representative may not actively manage the care for more than two Consumers participating in the consumer-directed option under this Section or another MaineCare or state funded long term care program. Specifically, the Representative must:

(1) Be at least eighteen (18) years of age;

(2) Have the ability to understand and perform tasks required to manage an Attendant as determined by the SCA;

(3) Have the ability to communicate effectively with the SCA, FI and Attendant(s) in performing the tasks required to employ an Attendant;

(4) Agree to visit the Consumer in person at least once a month and contact the Consumer in person, by phone or other means at least weekly;

(5) Not be an Attendant reimbursed for providing care to the Consumer; and

(6) Undergo criminal background checks and checks on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and the Maine APS Substantiation Registry.

63.10 RESPONSIBILITIES OF THE ASSESSING SERVICES AGENCY (ASA) AND THE SERVICE COORDINATION AGENCY (SCA)

63.10-1 ASA and the SCA Requirements

The ASAs and SCAs shall meet the following requirements:

A. Employ staff qualified by training and/or experience to perform assigned tasks and meet the applicable licensure requirements;

B. Comply with requirements of the Adult Protective Services Act, 22 M.R.S. §§ 3470-and 22 M.R.S. §§ 4011-17 to report any suspicion of abuse, neglect or exploitation;

C. Pursue other sources of reimbursement for services prior to the authorization of Home Based Supports and Services;

D. Operate and manage the program in accordance with all requirements established by rule or contract;

E. Have sufficient financial resources, other than federal or state funds, available to cover any Home Based Supports and Services expenditures that are disallowed as part of the Office of Aging and Disability Services utilization review process;

F. Inform in writing any Consumer or any designated Representative of a Consumer with an unresolved complaint regarding their services about how to contact the Long-Term Care Ombudsman;

G. Assure that costs to HBSS funds for services provided to a Consumer in a twelve (12) month period do not exceed the applicable annual authorized care plan cost limit, per level of care for which the Consumer is determined eligible, established by the Office of Aging and Disability Services; and

H. Assure when hiring or contracting for delivery of services that conflict of interest has been disclosed and measures taken to avoid the issue in provision of services. If conflict of interest is identified, document that specific measures have been taken to comply.

63.10-2 The SCA Requirements for Levels I-IV

The SCAs shall, for Levels I-IV:

A. Assure that service Providers employed by agencies and independent contractors meet applicable licensure and/or certification and/or training requirements and maintain records which show entrance and exit times of visits, total hours spent in the home, and tasks completed. Travel time to and from the location of the Consumer is excluded;

B. Maintain annual written agreements with service Providers employed by agencies and independent contractors, and communicate current policy or service rate changes to all Providers;

C. Implement an internal system to assure the quality and appropriateness of services delivered including, but not limited to the following:

(1) Consumer satisfaction surveys;

(2) Documentation of all complaints, by any party including resolution action taken; or

(3) Measures taken by the Authorized Agent to improve services as identified in (1) and (2);

D. Include a provision in service Provider agreements for reimbursing the Service Coordination Agency if services paid for by HBSS are subsequently reimbursed by another payor;

E. Establish MDTs who will review plans of care, as needed, to identify overlaps of service, over utilization of services or deficits in plans of care. Consider, as appropriate, any findings of the MDT when implementing the Authorized Plan of Care and issuing service authorizations. The registered nurse assessor is considered a member of the MDT;

F. Assure contact with each Consumer as required under the contract with The Department to verify receipt of authorized services, discuss Consumer's status, review any unmet needs and provide appropriate follow-up and referral to community resources;

G. Employ either directly, or through contract, care coordinators who meet the qualifications listed in 63.09-2(B).

H. Assure that all contracts for Personal Care Services and homemaker services require checks of the CNA registry and any required criminal background checks for all employees prior to the provision of services by the employees of the agency under contract;

I. Reimburse Providers in accordance with these rules and the SCA contract with the Department based on the unit of service and rates established by the Department;

J. Contract with a Fiscal Intermediary who agrees to perform employer-related tasks and administrative tasks specified in Section 63.02-18; and

K. Establish and maintain a record for each Consumer that includes at least:

(1) The Consumer's name, address, mailing address if different, and telephone number;

(2) The name, address, and telephone number of someone to contact in an emergency;

(3) Complete MED Form and financial assessments and reassessments that include the date they were done and the signature of the person who did them;

(4) A care plan summary that promotes the Consumer's independence, matches needs identified by the scores and timeframes on the MED Form and authorized by the Assessing Services Agency, gives consideration of other formal and informal services provided and which is reviewed no less frequently than semiannually. The service plan includes:

(a) Evidence of the Consumer's participation;

(b) Identification of needs;

(c) The desired outcome;

(d) A Back Up Plan;

(e) Who will provide what service, when and how often, reimbursed by what funding source, the reason for the service and when it will begin and end; and

(f) The signature the nurse assessor who determined eligibility and the Authorized Plan of Care and the SCA staff who authorized the service plan.

(5) A dated release of information signed by the Consumer that conforms with applicable state and federal law is renewed annually and that:

(a) Is in a language the Consumer can understand;

(b) Names the agency or person authorized to disclose information;

(c) Describes the information that may be disclosed;

(d) Names the person or agency to whom information may be disclosed;

(e) Describes the purpose for which information may be disclosed; and

(f) Shows the date the release will expire.

(6) Documentation that Consumers eligible to apply for a waiver for Consumer payments, were notified that a waiver may be available;

(7) A copy of the Consumer's signed and dated request form authorizing the Service Coordination Agency to arrange services described in the Authorized Plan of Care;

(8) Monthly service orders to Providers that specify the tasks to be completed; and

(9) Written progress notes that summarize any contacts made with or about the Consumer and:

(a) The date the contact was made;

(b) The name and affiliation of the person(s) contacted or discussed;

(c) Any changes needed and the reasons for the changes in the Authorized Plan of Care;

(d) The results of any findings of MDT contacts or meetings; and

(e) The signature and title of the person making the note and the date the entry was made.

63.10-3 Written Progress Notes

Written progress notes for services delivered by a Direct Care Provider (includes SCA sub-contracted agencies) shall contain:

A. The service provided, date, and by whom;

B. Visit entrance and exit times of nurses, home health aides, certified nursing assistants and Personal Support Specialists and total hours spent in the home for each visit. Exclude travel time (unless provided as a service as described in this Section);

C. A written service plan that shows specific tasks to be completed and the schedule for completion of those tasks;

D. Progress toward the achievement of long and short range goals. Include explanation when goals are not achieved as expected;

E. Signature of the service Provider; and

F. Full account of any unusual condition or unexpected event, dated and documented.

63.10-4 Program Reports

Each SCA shall keep records and submit reports to the Department as specified in the contracts between the Department and the SCAs.

63.11 RESPONSIBILITIES OF THE OFFICE OF AGING AND DISABILITY SERVICES

63.11-1 Selection of Authorized Agent

To select the Assessing Services Agency and the Service Coordination Agency, the Office of Aging and Disability Services will request proposals by publishing a notice in Maine's major daily newspapers and posting on the Office of Aging and Disability Services' website. The notice will summarize the detailed information available in a request for proposals (RFP) packet and will include the name, address, and telephone number of the person from whom a packet and additional information may be obtained. The packet will describe the specifications for the work to be done. Criteria used in selection of the successful bidder or bidders will include but are not necessarily limited to:

A. Cost;

B. Organizational capability;

C. Response to a sample case study;

D. Qualifications of staff;

E. References;

F. Quality assurance plan;

G. Ability to comply with applicable program policies; and

H. Demonstrated experience.

63.11-2 Other Responsibilities of OADS

The Office of Aging and Disability Services is responsible for:

A. Setting the annual Consumer care plan cost limit for each level of care;

B. Establishing performance standards for contracts with authorized agencies including but not limited to the numbers of Consumers to be assessed and served and allowable costs for administration and direct service;

C. Conducting or arranging for quality assurance reviews that will include record reviews and home visits with HBSS Consumers;

D. Providing training and technical assistance;

E. Providing written notification to the administering agencies regarding strengths, problems, violations, deficiencies or disallowed costs in the program and requiring action plans for corrections;

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F. Assuring the continuation of services if the Office of Aging and Disability Services determines that an Authorized Agent's contract must be terminated;

G. Administering the program directly in the absence of a suitable Authorized Agent;

H. Conducting a request for proposals for authorized entities at least every five (5) years thereafter;

I. At least annually, review randomly selected requests for waivers of Consumer payment;

J. Recouping HBSS funds from administering agencies when Office of Aging and Disability Services determines that funds have been used in a manner inconsistent with these rules or the Authorized Agent's contract; and

K. Implementing a waiting list for Consumers until resources are available.

63.12 CONSUMER PAYMENTS

THE FOLLOWING SUBSECTION OF THIS RULE IS MAJOR SUBSTANTIVE PURSUANT TO 34-B M.R.S. § 5439(9).

The administering agency will use an Office of Aging and Disability Services approved form to determine the individual’s Income and Liquid Assets and calculate the monthly payment to be made by the Consumer. The agency may require the Consumer and their spouse to produce

documentation of Income and Liquid Assets. A Consumer need not complete a financial assessment if they pay the full cost of services received. Their payments, as determined by an annual financial assessment may not exceed the total cost of services provided. For Level I-IV, the final Consumer payment will be determined by the SCA. For Level V, the final Consumer payment will be determined by the Licensed Assisted Living Agency.

63.12-1 Consumer Payment Formula

The Provider agency will use the following formula to determine the amount of each Consumer's payment, excluding Consumers who received services pursuant to 14-197 C.M.R. ch. 11 on June 30, 2023. Consumers who received services pursuant to 14-197 C.M.R. ch. 11 on June 30, 2023, are subject to the consumer payment formula in subsection 63.12-2.

Step 1: Calculate the Monthly Contribution from Income.

A. Total the monthly Income of the Consumer and spouse.

B. Deduct monthly allowable Disability Related Expenses.

C. Deduct monthly allowable dependent allowances.

D. Multiply the net Income by 4%.

Step 2: Calculate the Monthly Contribution from Liquid Assets.

A. Total the Liquid Assets of the Household Members.

B. Deduct annual interest and annual dividends counted towards Income for the Household Members.

C. Subtract $15,000 from the amount of Liquid Assets calculated in Step 2(A & B). If the result is less than zero, use zero.

D. Multiply the sum calculated in Step 2(C) by 3%. The result is the Monthly Contribution from Liquid Assets

Step 3: Add the result of the calculation in Step 1(D) to the result of the calculation in Step 2(D).

Step 4: The Consumer's monthly payment is the lesser of the sum calculated in Step 3 or the actual cost of services provided during the month.

Step 5: When two (2) persons in a household are both receiving Home Based Supports and Services pursuant to this Section, collect the required information for each person. Calculate the co-pay for each Consumer and

combine the total. Divide the amount by two to determine the household monthly co-payment.

63.12-2 Consumer Payment Formula for Former Chapter 11 Consumers

The following Consumer payment formula applies only to Consumers who received 14-197 C.M.R. ch. 11, services on June 30, 2023. The Provider agency will use the following formula to determine the amount of each Consumer's payment.

Step 1: Calculate the Monthly Contribution from Income.

A. Total the monthly Income of the Consumer and spouse.

B. Deduct monthly allowable Disability Related Expenses.

C. Deduct monthly allowable dependent allowances.

D. Multiply the net Income by 4%.

Step 2: Calculate the Monthly Contribution from Liquid Assets.

A. Total the Liquid Assets of the Household Members.

B. Deduct annual interest and annual dividends counted towards Income for the Household Members.

C. Subtract $30,000 from the amount of Liquid Assets calculated in Step 2(A & B). If the result is less than zero, use zero.

D. Multiply the sum calculated in Step 2(C) by 3%. The result is the Monthly Contribution from Liquid Assets

Step 3: Add the result of the calculation in Step 1(D) to the result of the calculation in Step 2(D).

Step 4: The Consumer's monthly payment is the lesser of the sum calculated in Step 3 or the actual cost of services provided during the month.

Step 5: When two (2) persons in a household are both receiving home based care services pursuant to Chapter 11, collect the required information for each person. Calculate the co-pay for each Consumer and combine the total. Divide the amount by two to determine the household monthly co-payment.

63.12-3 Waiver of Consumer Payment

A. Consumers may request a waiver from the Service Coordination Agency or the Licensed Assisted Living Agency for all or part of the assessed payment when:

(1) Monthly Income of Household Members is no more than 200% of the Federal Poverty Level as defined by the Federal Poverty Guidelines from https://aspe.hhs.gov/poverty-guidelines; and

(2) Household Assets are no more than:

(a) $ 30,000 for Consumers who received 14-197 C.M.R. ch. 11, services on June 30, 2023; or

(b) $ 15,000 for all other Consumers.

B. Consumers requesting waivers may be asked to provide verification of any Income, Liquid Assets and expenses for housing, transportation, unreimbursed medical expenses, food, clothing, laundry and insurance.

C. The request must be submitted in writing, on a Department approved form, to the SCA or the Licensed Assisted Living Agency within ten (10) business days of the date of:

(1) Notification of the assessed Consumer payment;

(2) The Consumer's last functional reassessment; or

(3) The start of the Consumer's services after being on the waiting list.

D. The SCA or Licensed Assisted Living Agency must inform the Consumer of its decision in writing within twenty (20) days of receipt of the request. If denied, the SCA or Licensed Assisted Living must include information on appeal rights.

E. If the SCA or Licensed Assisted Living Agency needs additional information, in order to determine whether the waiver can be granted, they will promptly notify the Consumer. The Consumer must submit the additional information within ten (10) business days. In such cases, the SCA or Assisted Living Agency must issue its decision within ten (10) business days of receipt of the additional information.

F. A Consumer who is otherwise eligible may receive services while awaiting the decision on the request for waiver. The SCA or Licensed Assisted Living Agency will hold the Consumer payment in abeyance pending a decision on the request, or the completion of the appeals process, whichever is later

G. If the waiver is denied, the Consumer payment, including payments held in abeyance, is due within thirty (30) business days of the date of the decision, or services will be terminated.

H. Consumers who have applied for a full or partial waiver of the assessed payment and been denied may reapply only if one (1) of the following conditions exists and is expected to continue until the next regularly scheduled financial assessment:

(1) The Consumer has at least a 20% decrease in monthly Income or Liquid Assets; or

(2) The Consumer has an increase in expenses which results in the sum of the allowable expenses plus the Consumer payment exceeding monthly Income plus the monthly contribution From Liquid Assets.

I. When allowable expenses plus the Consumer payment exceed the sum of monthly Income plus the monthly contribution from Liquid Assets, the agency will waive the portion of the payment that causes expenses to exceed Income.

63.12-4 Expenses

Expenses will be reduced by the value of any benefit received from any source that pays some or all of the expense. Examples include but are not limited to: Medicare; MaineCare; Food Stamps; and Property Tax and Rent Refund.

Business expenses that exceed business Income are not allowable.

Allowable expenses include actual monthly costs of all household members for:

A. Housing expenses which include and are limited to rent, mortgage payments, property taxes, home insurance, heating, water and sewer, snow and trash removal, lawn mowing, utilities and necessary repairs;

B. Food, clothing and laundry not to exceed the amounts provided in the following chart;

Number in Household	1	2	3	4	5 & up
Amount	$262	$412	$553	$695	$837

C. Transportation expenses which include and are limited to ferry or boat fees, car payments, car insurance, gas, repairs, bus, car and taxi fare;

D. Unreimbursed medical expenses including but not necessarily limited to health insurance; prescription or physician ordered drugs, equipment and supplies; and doctor, dentist and hospital bills;

E. Life insurance; and

F. Limited discretionary expenses not to exceed the amounts provided in the following chart. Amounts in excess of the monthly allowance may not be claimed.

Number in Household	1	2	3	4	5 & up
Amount	$76	$120	$161	$203	$244

STATUTORY AUTHORITY: 22 M.R.S. § 7303(2); 34-B M.R.S. § 5439(4)

EFFECTIVE DATE:

APPENDIX: TASK TIME ALLOWANCES- ACTIVITIES OF DAILY LIVING

ACTIVITY	DEFINITIONS	TIME ESTIMATES		CONSIDERATIONS
BED MOBILITY	**HOW PERSON MOVES TO AND FROM LYING POSITION, TURNS SIDE TO SIDE AND POSITIONS BODY WHILE IN BED.**	**5 – 10 MINUTES**		Positioning supports, cognition, pain, disability level.
TRANSFER	**HOW PERSON MOVES BETWEEN SURFACES – TO/FROM: BED, CHAIR, WHEELCHAIR, STANDING POSITION (EXCLUDE TO/FROM BATH/TOILET).**	**5 – 10 MINUTES** **up to 15 minutes**		Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition **Mechanical Lift transfer**
LOCOMOTION	**HOW PERSON MOVES BETWEEN LOCATIONS IN HIS/HER ROOM AND OTHER AREAS ON SAME FLOOR. IF IN WHEELCHAIR, SELF-SUFFICIENCY ONCE IN CHAIR.**	**5 - 15 MINUTES (DOCUMENT TIME AND NUMBER OF TIMES DONE DURING POC)**		Disability level, Type of aids used or Pain
DRESSING & UNDRESSING	**HOW PERSON PUTS ON, FASTENS AND TAKES OFF ALL ITEMS OF STREET CLOTHING, INCLUDING DONNING/REMOVING PROSTHESIS.**	**20 - 45 MINUTES**		Supervision, disability, pain, cognition, type of clothing, type of prosthesis.
EATING	**HOW PERSON EATS AND DRINKS (REGARDLESS OF SKILL)**	5 minutes		Set up, cut food and place utensils.
		30 minutes		Individual is fed.
		30 minutes		Supervision of activity due to swallowing, chewing,
TOILET USE	**HOW PERSON USES THE TOILET ROOM (OR COMMODE, BEDPAN, URINAL); TRANSFERS ON/OFF TOILET, CLEANSES, CHANGES PAD, MANAGES OSTOMY OR CATHETER AND ADJUSTS CLOTHES.**	**5 -15 MINUTES/USE**		Bowel, bladder program Ostomy regimen Catheter regimen cognition
PERSONAL HYGIENE	**HOW PERSON MAINTAINS PERSONAL HYGIENE.** **(EXCLUDE BATHS AND SHOWERS)**	**WASHING FACE, HANDS, PERINEUM, COMBING HAIR, SHAVING AND BRUSHING TEETH**	**20 MIN/DAY**	**DISABILITY LEVEL, PAIN, COGNITION, ADAPTIVE EQUIPMENT.**
		Shampoo (only if done separately)	15 min up to 3 times/ week	
		NAIL CARE	**20 MIN/WEEK**	

WALKING	**A. HOW PERSON WALKS FOR EXERCISE ONLY** b. How person walks around own room c. How person walks within home d. How person walks outside	**DOCUMENT TIME AND NUMBER OF TIMES IN POC, AND LEVEL OF ASSIST IS NEEDED.**	**DISABILITY** **COGNITION** **PAIN** **MODE OF AMBULATION (CANE)** Prosthesis needed for walking
BATHING	**HOW PERSON TAKES FULL-BODY BATH/SHOWER, SPONGE BATH (EXCLUDE WASHING OF BACK, HAIR), AND TRANSFERS IN/OUT OF TUB/SHOWER**	**15 - 30 MINUTES**	If shower used and shampoo done then consider as part of activity, cognition**.**